Title:

"Don't mind me, I'm just the parent"

An investigation into the therapeutic alliance between staff and parents in a child in-patient psychiatric unit.

By

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature Signed by candidate Date 7 Sept 2004

ABSTRACT

This study is a qualitative exploration of the concept of therapeutic alliance between staff and parents in a child in-patient psychiatric unit, namely the Therapeutic Learning Centre (T.L.C), at the Red Cross Children's Hospital in Cape Town. The aims of the study were to firstly, explore how parents experience the process of admission and treatment of their child to a psychiatric in-patient unit and secondly, to ascertain what factors foster or inhibit therapeutic alliance between staff and parents. Semi-structured interviews were conducted with the psychologist and relevant nurses of the T.L.C and the parents of two children who had been admitted to the unit. Initial interviews were conducted shortly after admission of each child, and follow-up interviews were conducted on discharge for the first case and midway through the treatment of the second case. In addition, participant observation was employed by attending the multidisciplinary case conferences at the T.L.C. Interviews were recorded and transcribed, the data was analysed by using thematic analysis. The themes which emerged were informed by current research trends in in-patient child psychiatry. The dominant issues relevant to parental experiences are: a) the trauma inherent in living with and caring for a psychiatrically ill child and b) the ambivalent feelings that arise from admission and treatment which are often related to parents' unconscious fears of being blamed for their child's condition. This study has shown that therapeutic alliance is comprised of many variables that affect both staff and parents, and that these variables may be both unconscious and conscious. Furthermore, therapeutic alliance cannot be assessed merely by the attendance of the parents at the meetings prescribed by the unit. The study concludes with a consideration of the limitations of this research and recommendations for both future research and clinical practice are made.

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CHAPTER ONE

1. INTRODUCTION

1.1. Background to the Study

The Therapeutic Learning Centre (T.L.C) is the in-patient psychiatric unit of Red Cross Children's Hospital in Cape Town. In 2002 the clinical team completed a research proposal for a quantitative study that would explore parental involvement as one of the important indicators for outcome of treatment, namely health gain[1]. In its analysis of cases deemed to have shown poor outcome on follow-up, the unit staff consistently found that a breakdown in the therapeutic alliance with the parents was the most common factor. The proposed quantitative study hopes to enable the unit to investigate the role and effect of parental alliance on the outcome of the child's treatment. Results may then be used to inform the development of a parental program which could be applied to the clinical setting of the T.L.C.

In a climate characterized by scarce resources and a growing need to prove the effectiveness of in-patient treatment for severely disturbed children, the proposed quantitative study has been welcomed by the research committee of the University of Cape Town (U.C.T). The study aims to use quantitative measures to assess changes in the child's behaviour such as the CBCL - Child Behaviour Checklist (Achenbach & Edelbrock, 1983) and the HONOSCA - Health of the Nation Outcome Scales for Child and Adolescent Mental Health (Gowers, Harrington, Whitton, Lelliott,

[1] Health gain is a generalised term describing the improvements made in the presentation of the symptoms of the diagnosed disorder. It does not equate to outcome, which is a broader concept. Health gain is usually determined after discharge, is influenced by factors post treatment, such as appropriate school placement, and involves adjustment to the demands of everyday life. This is based on the tripartite model advocated by Strupp & Hadley (1977) which looks at outcome from three major vantage points: the patient, society and the clinician (Green & Jacobs, 1998).

Beevor, Wing & Jezzard, 1999). Family involvement would be measured by the Family Engagement Questionnaire (Kroll & Green, 1997). It would then be possible to assess if children who did not improve were also the same children whose family was unengaged with the unit. However, the proposed study does not call on the parents to rate the unit in terms of the unit's ability to involve and engage the family. Nor does the study address the factors that can foster or inhibit parental involvement. When investigating the relationship between family engagement (as a measure of therapeutic alliance) and health gain, it is imperative to know and explore what fosters family engagement in the first place. It was felt by the reviewers (U.C.T Health Sciences Research Board) of the research proposal that the study failed to include a qualitative understanding of the concept of parental involvement. This study aims to address these two central issues. Namely:

1. How do parents experience the admission and treatment of their child to a psychiatric in-patient unit?
2. What fosters or hinders therapeutic alliance in child in-patient psychiatry?

Although the quantitative research proposal was approved, due to staff constraints the T.L.C has temporarily placed the study on hold. The unit is currently operating without a social worker, and thus the psychologist has to take on the social work function as well.

Research within a child psychiatric in-patient unit is a difficult task. It requires motivation and support from the already burdened staff to participate in and co-operate with the research process (Riddle, 1989). Staff may see the research as an additional burden and it can lead to a conflict in priorities.

The staff was willing to assist in my research as it was seen as a means to continue the qualitative aspects of the study without placing an extra burden on the currently understaffed unit. As a volunteer at the T.L.C during 2002 I was involved in the formulation of the quantitative research proposal, but have since not been attached to the unit. Although the quantitative study is currently on hold, it is hoped that the results obtained in this study will be of use to the staff of the T.L.C. It may provide staff with developing a broader understanding of the needs and issues faced by parents when admitting their child to the T.L.C. The qualitative data may also be used to support and inform the proposed quantitative study.

CHAPTER TWO

2. LITERATURE REVIEW

2.1. Introduction

There is a scarcity of literature on the concept of therapeutic alliance in in-patient child psychiatry. Nonetheless, this review aims to provide a comprehensive understanding of this issue in the field of in-patient psychiatry as well as the different facets contributing to therapeutic alliance. What is noteworthy is that the literature is drawn predominantly from the United Kingdom and the United States, as there is a shortage of relevant South African writing in the field of in-patient child psychiatry. "Third World" countries have few child in-patient psychiatric units, as such units remain highly specialized and are expensive to run.

The first half of the literature review explores the historical context of in-patient child psychiatry. Particular emphasis is placed on the confusion in terminology as well as the global shifts and trends in mental health care services, for example: the debates surrounding in-patient versus community based care. The South African in-patient child psychiatric context is presented. Thereafter the complexities of conducting research in an in-patient setting are examined. The concept of therapeutic alliance in in-patient child psychiatry leads into a discussion on the issues facing a family of a child admitted to an in-patient psychiatric hospital. The scarcity in relevant literature is apparent throughout the review but is particularly noticeable when considering the importance of family involvement.

The second half of the literature review considers the issues within in-patient child psychiatry from a psychoanalytic framework[2]. The psychoanalytic perspective seeks to understand the unconscious aspects that influence a family's sense of connectedness to the unit. The unconscious aspects of organizations are briefly discussed as a means of explaining staff dynamics which may influence the therapeutic alliance between the unit and the parents.

2.2. Therapeutic Communities

There is a long standing history of residential care, confinement and in-patient treatment as part of society's response to handicapped children, psychotic children and homeless children and to those children presenting with a wide range of emotional and behavioural disorders (Parry-Jones, 1998). With the exception of such studies as Beskind (1962) in the United States and Barker (1974) in the United Kingdom, there have been very few systematic studies into the history of residential care and treatment of children in hospital. Parry-Jones (1989, 1994, 1998) also provides a detailed history of the developments and trends in residential care, however there remains confusion as to what constitutes residential care.

The concept of the therapeutic community was an innovative one, which emerged in the 1940's, and marked a dramatic move toward the more humane treatment of psychiatric patients (Kasinski, 2003). There is, however, much confusion about the terms 'therapeutic community', 'therapeutic milieu' and 'milieu therapy', all of which imply a manner of working and the confines within which treatment occurs. Many authors use these terms interchangeably. This has had far reaching implications for research and standardized practices within the field. Fees (1998) explains that the confusion in terminology would not in itself be a problem if, within or even

[2] Gibson (2002) mentions that clinical psychologists in South Africa, who identify with the framework, use the softer term of 'psychodynamic' as opposed to psychoanalytic to illustrate the lack of purity in the models adopted. This thesis uses the terms interchangeably.

amongst themselves, the terms consistently designated the same things, but they don't: "Some hospitals, for example, record the treatment given to a psychotic patient who has received little more than three meals a day and a bed each night as milieu therapy." (Cumming & Cumming, 1964, p. 1).

In contrast Ward, Kazinsky, Pooley & Worthington (2003, p. 11) describe therapeutic communities as "a specialized unit for children, usually residential and often incorporating education as well as care, and usually organized on the basis of offering planned therapeutic help and support over a period of two to three years." Although therapeutic communities operate mainly in residential care settings, the range of applications is wide, including psychiatric care, special education and family centres.

Kutash & Rivera (1996) explain that within the United Kingdom there has been a need to define a continuum of care services, both residential and non-residential, within the children's mental health services system. At the most restrictive end of the continuum are residential services, including residential treatment centres and in-patient hospitals. During hospitalisation the child is removed from the home and hospital staff undertakes total care of the child. A large range of interventions are used, including individual, family and group therapy, pharmacotherapy, milieu therapy and behavioural modification. Although a wide possibility of residential services are available for children, in the context of this thesis psychiatric care will remain the focus.

2.2.1. Child in-patient psychiatric units

The earliest in-patient units had a mainly custodial and management function, but later there were moves toward the use of the in-patient setting as a therapeutic agent in itself. According to Barker

(1974), hospital units especially for the treatment of children first started in the United States in the 1920's. These units cared for children with behavioural disorders following an encephalitis epidemic. In the United Kingdom the Second World War resulted in large numbers of evacuee children. This in turn stimulated the rapid post-war growth of child mental health and social work services, including the establishment of in-patient psychiatric units for children and adolescents. The in-patient ward at the Maudsley Hospital was opened in 1947. In "first world" countries, the 1960's and 70's saw a rapid expansion of such services, which was driven by public and political concerns and which included the recognition that children and adolescents are at risk when admitted to adult units.

Modern in-patient units usually include the disciplines of child psychiatry, nursing, psychology, social work, education and occupational therapy (Hersov, 1998). The use of in-patient units is usually reserved for the most severe and/or complex cases that cannot be managed effectively by community services (Maskey, 1998). Children who are admitted spend 24 hours a day in the unit. Depending on the individual unit's ethos, resources and diagnosis of the child, some in-patients do go home over weekends. There is no uniform structure across different child in-patient psychiatric units and many operate as both day and in-patient units.

2.2.2. Child day patient psychiatric units

Stroul & Friedman (1986, p.44) define day treatment as "a service that provides an integrated set of educational counselling, and family interventions that involve a youngster for at least five hours a day." There is a continuum of day programs ranging from partial hospitalisation to school based day programs. Partial hospitalisation refers to the use of a psychiatric hospital setting for less than 24 hours-a-day care, with children returning to their homes at night (Kutash and

Riviera, 1996). Despite calls from within the profession for more consistency, in-patient units have tended to develop idiosyncratically according to local conditions and staff personalities (Green, 1992). Although there is a need for units to be able to accommodate a wide range of conditions, many units do tend to develop particular areas of expertise that can lead to a bias in the kinds of referrals they receive. Within South Africa, such a referral bias is less likely to occur, as there are few in-patient facilities available for children with psychiatric illnesses.

2.3. The South African Context

In the majority of westernised countries the aim of government policy is health service delivery along a 4-tier system. The Department of Health's (1999) paper on the transformation of the health system in South Africa adopts a similar approach. The tiers are described as follows:

- the primary health care level that operates in the community,
- the secondary level at designated "area" sites,
- the tertiary level of specialized units fulfilling regional obligations
- and the super-tertiary, highly specialized units that carry supra-regional or national responsibilities.

In child mental health, day and child in-patient psychiatric units are regarded as "super-tertiary" and are expected to fulfil regional service delivery obligations (de Jager, 2001). Such units are low volume, high cost services and are similar to other highly specialist or intensive care facilities throughout medicine. Green & Jacobs (1998) refer to in-patient child psychiatry as the intensive care of child mental health.

The focus of government health policy in post-apartheid South Africa is on the development of a primary care infrastructure that is equitable, accessible and available to all South Africans (Department of Health, 1999). Mental health services at this level for children remain under-developed, and under-resourced (Moodley & Pillay, 1993). Nonetheless, the Western Cape Health Department has continued to fund a child in-patient psychiatric unit in the province, namely the Therapeutic Learning Centre (T.L.C).

It was very difficult to obtain a list of child in-patient psychiatric services available within South Africa. Numerous telephone calls to the Department of Health yielded no central database of mental health services available for children. On contacting the Western Cape regional office the researcher was given two other hospital names as in-patient treatment facilities. However, telephonic enquiry directly with the hospitals confirmed that both hospitals do not, in fact, have such facility. It is also noteworthy that the regional office of the Department of Health did not mention the T.L.C, which is based at Red Cross Children's Hospital. During the apartheid era the provision of services was inequitably divided based on race. During the last decade of democracy the government has attempted to merge services but it remains difficult to ascertain the specific facilities that government continues to fund for child psychiatric care. However, it does seem that the T.L.C is the only child in-patient psychiatric unit in the Western Cape and possibly throughout the country (with the probable exception of Gauteng). This results in the T.L.C accepting patients from other provinces such as the Eastern Cape.

2.4. Admission for In-patient Treatment

Admission for in-patient treatment is a contentious issue. The debate has its roots in the 19th century where opposition to institutions and workhouses was based on the notion that they

advocated and encouraged the abandonment of children (Parry-Jones, 1998). Allbutt (1899, as cited in Parry-Jones, 1998) insisted that insane children, unless seriously disturbed could be managed at home, thereby avoiding the 'systematic watchfulness' of asylum doctors. This is in contrast to the prevailing mindset of physicians in the 19th century who favoured the removal of children from their homes in order to establish control, unhindered by parental and family interference (Parry-Jones, 1998). Historically, parents were excluded from child psychiatric units, a practice which has its origins in the notion of "parent as pathogen" (Harper & Cotton, 1991, p.332). In this model there is an assumption that the parents are responsible for the problems of their child and that separation is necessary in order for the child to give up their ineffective defences and develop new coping skills.

During the last quarter of the 20th century, spearheaded by the United States, the health service climate was influenced by a system of managed health care[3] and evidence based practice. This resulted in many units being closed. The closing of units was also supported by the often cheaper community based approaches and the growing awareness of the needs and rights of children. The concerns raised about institutional facilities for child in-patient units were:

- should children be separated, through admission, from their families?
- community therapeutic skills have been developed and should be utilised.
- in-patient milieus cultivate dependency and immaturity.

(Lelliot, Jaffa & Hill, 1999)

[3] A health care delivery system that controls the price, amount, location and intensity of health services provided to its members in an effort to control health are costs and/or improve the quality of care (USAA Educational Foundation, n.d)

However, Green & Jones (1998) warn against assuming that in-patient treatment necessarily has negative consequences. They advocate empirical research to address the actual incidence of unwanted effects rather than a reliance solely on theoretical or anecdotal concerns. They do recognize, however, that within the in-patient environment unwanted effects may certainly arise. These include:

For the child:

- The milieu is an intense and challenging environment and can be frightening, hostile or even abusive.
- The child may perceive the admission as a punishment.
- Aggression between peers may arise.
- Sexual acting out or exploitation may occur.

For the Family/Parents:

- Parents are frequently concerned that other patients may negatively affect their child.
- Admission may reinforce a covert rejection or scapegoating of that child from the family.
- Parents may feel deskilled, and blamed by the staff.
- Difficulties with time off work and the expense of travel for parents may arise, which may limit opportunities for them to visit their child.

Whilst there has been general recognition that family centred approaches in the community offer the most effective and optimal treatment for most children, it has also been recognized that there continues to be a group of children that need highly specialized care. Such specialized care offers focused, observed assessments that assist with diagnosis for conditions such as neuropsychiatric

disorders, unrecognised mood conditions and undisclosed trauma (de Jager, 2001). There remains a cohort of children who cannot be effectively managed by outpatient therapeutic treatment. In the United Kingdom, this acknowledgement has lead to a re-opening of units and a proliferation of studies in this area (Jacobs, Green, Huxley, Dunn, James, Clark, & Pipe, 1999; Worral & O'Herlihy, 1999), many forming part of the NICAPS (National In-patient Child and Adolescent Psychiatry Study), which provides a comprehensive and detailed review of these services in England and Wales.

Managed care in combination with the debates referred to above have also influenced the duration of admission for children in in-patient units. Duration is a variable that is dependent on elements such as diagnosis and the ethos of the unit. In the United States the length of in-patient stays began shrinking in the 1980's. Many units report an average stay of 14 days (Scharer, 2002). This short-term model of hospitalisation, popular in the United States, aims to achieve the minimal changes required in order for the child to return to the community. Such an approach also supports the active involvement of parents with all aspects of admission as well as in discharge planning.

However, when psychiatric hospitalisation lasts for between four to six months or longer, the focus of the hospitalisation is directed toward restructuring the child's defences and problem behaviours and rebuilding new, more successful defence mechanisms (Sharer, 2002). The aim of admission is central when considering criteria for discharge and when examining outcome-based research. A slight change in behaviour may be the cue for success and discharge in one unit and merely the starting point for another.

The debates in the field of in-patient child psychiatry remain hampered by the confusion in terminology, the heterogeneous nature of the units themselves and the lack of empirical research focusing on effective outcome. In addition, the current economic climate demands justification and accountability of units that are characterised by high cost and low volume.

2.5. Child In-patient Psychiatric Research: Issues and Complexities

In recent years, several studies and reviews have been conducted which focus on different aspects of child in-patient psychiatric units (Riddle, 1989; Blanz & Schmidt, 2000; Green, 1992; Kutash & Rivera, 1996). A child in-patient psychiatric unit provides professionals with the ideal opportunity to observe and assess children, as well as the means to evaluate the effectiveness of various treatments. This creates a potential environment for substantive and insightful research (Riddle, 1989; Kutash & Rivera, 1996).

However, many difficulties have been noted in this process. For one, samples are generally small as the intake of these in-patient units is limited. This, in turn, limits the quality in terms of generalisability, and quantity of research that may be conducted (Green & Jacobs, 1998). In addition, there are inconsistencies surrounding how improvement in child outcome is conceptualised and operationalized (Blanz & Schmidt, 2000). Furthermore, there may be difficulties in motivating staff to participate in and co-operate with the research process as resources are often limited (Riddle, 1989). As Imrie & Green (1998, p.337) observe:

> The field of research into in-patient efficacy and process is in the early stages of maturity; a stage where there are a relatively small number of disconnected studies in the literature, of uneven quality, using heterogeneous samples and non shared or non-standardized

assessments. There are no randomized controlled studies and no completed studies of treatment process in addition to outcome.

There is clearly a need for research in this area. Firstly, such research would provide an invaluable empirical basis for much of the clinical work conducted at in-patient units. This will allow for more well-informed treatment and clinical practice. Secondly, in-patient care is expensive and motivation for funding is a constant issue. Despite limitations, literature reviews have found that in-patient stays can be beneficial and generally lead to a successful outcome (Pfeiffer & Strzelecki, 1990; Green & Jacobs, 1998). In-patient research would hopefully provide well-grounded reasons why psychiatric child in-patient units should continue to receive funding (Blanz & Schmidt, 2000; Riddle, 1989; Kutash & Rivera, 1996). A particular area, which has had little, systemized empirical research conducted, is the question of what the best circumstances are for the most successful child outcome.

In a useful paper to emerge in this field, Pfeiffer & Strzelecki (1990) analysed the predictive power of ten significant patient and process variables with regard to outcome. They concluded that 'organicity', a low I.Q (Intelligence Quotient), anti-social symptom pattern, a psychotic or conduct disorder diagnosis, poor family functioning, poor therapeutic alliance, short length of stay and no post-discharge arrangements were related to poor long-term outcome. In their summary of the current status of efficacy research in this field, Imrie & Green (1998) recommend that the functioning of the unit and the staff and the relationship between the patient /family and the unit are the variables in need of further study. These variables address the therapeutic mode of action of the milieu that may impact on patient outcome. It is not possible to control for these variables in outcome based research if we do not understand them and develop techniques to

measure them effectively. Two crucial therapeutic variables are: ward atmosphere and therapeutic alliance.

2.5.1. Ward atmosphere.

There is little doubt that the quality of the environment and the milieu functioning impact upon the child during admission. The atmosphere in any ward is a difficult state to measure, as it is dynamic and is comprised of so many variables itself. In adult psychiatry Moos developed the Ward Atmosphere Scale (Moos 1974, as cited in Imrie & Green, 1998). This scale, however, measures the enduring aspects of the ward and is less sensitive to transient fluctuations. In contrast, Imrie & Green (1988) sought to assess the subtle changes in the milieu environment over a period of weeks. The scale they developed remains unpublished, but it does attempt to investigate some of the fluctuations (such as staff numbers, patient characteristics and ward events) and their consequences on morale and patients' attitudes and behaviour.

2.5.2. Therapeutic alliance

Therapeutic alliance is a concept that describes the relationship that exists between the patient and the caregiver. The conceptualisation of the elements that make up this relationship in working with children, has been operationalized in research by concepts such as parental involvement / participation (Prentice-Dunn, Wilson, & Lyman, 1981), the level of parental denial (Force & Sebree, 1985) and family motivation (Cohen, Kolers & Bradley, 1987).

Complexities in conceptualising and measuring therapeutic alliance during child in- and day patient treatment have been reviewed by Kroll & Green (1997). Although a large body of

literature exists on therapeutic alliance in adult psychiatry, there has been relatively little written on therapeutic alliance in child psychiatry. Within the field of child psychiatry separate alliances may develop between parents and members of the multi disciplinary team and the child and members of the team. Different disciplines are involved in different roles with members of the family; for example, nursing staff often fulfil an "in loco parentis" role for the child, while the social worker is often a support for the parents (Green & Jacobs, 1998). The nature of these relationships is likely to affect how the parent or child experiences the admission and, in turn, this may affect attitude and thus engagement with the goals of the unit. There is limited research which assesses parental and/or family engagement in the treatment of child psychiatric disorders. Kutash & Rivera (1996, p.192) conclude, in their summary of efficacy research on day patient units, "the involvement of the family in the treatment of the child has a significant impact on the outcome."

Techniques employed to investigate parental involvement usually measure attendance and lack any investigation into the quality of engagement. Kroll & Green (1997) were the first to develop and validate a questionnaire that assesses the level of child and parental alliance with specific reference to child psychiatric treatment. Other measures of parental involvement, such as the Parental Alliance Measure (PAM), assess how united the parents are in their parenting techniques and approach to their child (Konold & Abidin, 2001) and thus, does not address the issue of the therapeutic relationship between family and the in-patient unit. In their validation of the Family Engagement Questionnaire, Kroll and Green (1992) divided family engagement into parental alliance with the unit and child alliance. Child alliance includes relations to peers, engagement in activities and relation to staff. However, the Family Engagement Questionnaire remains a measure that assesses alliances from the staff's perspective. Searches on several Internet search engines yielded no measure that enabled the parents to rate the psychiatric unit's facilitation of

engagement, or a technique that enabled the staff to assess parental perspectives of the unit/treatment. The incorporation of a user and carer perspective on outcomes is a key challenge in the attempt to broaden and deepen the understanding of treatment effectiveness (Jacobs & Green, 1998).

Exactly what is meant by involvement, engagement or alliance has not been clearly defined in the literature. The terms are used interchangeably and this leads to confusion when attempting to assess the quality of the relationship as a predictor of outcome. Does a parent need to be merely involved (i.e. attend meetings and visit their child) or does a positive working alliance need to exist? The field of nursing seems to be at the forefront of publishing research that assists in understanding and developing the concept of relationship building from both a parental and staff perspective in child psychiatric units (Scharer, 1999,2000,2002; Puotiniemi, Kyngas & Nikkonen, 2000). Perhaps this is because nurses are most involved with both the parents and the child on a daily basis. The clinical team (psychiatrists, psychologists and social workers) seem to be more removed from the parents; they are seen mainly during scheduled appointments or feedback sessions.

Scharer (1999) in her paper entitled "Nurse-Parent Relationship Building in Child Psychiatric Units" explores the concept of working alliance. The paper is based on an American model of in-patient child psychiatric care that advocates shorter hospitalisations. However, it is a study that examines the relationship from both the nurse and parent perspective. Scharer identifies two phases in the relationship, namely the admission phase and the working phase.

2.5.2. a) The admission phase

The time leading up to admission and the admission itself (the initial stages of assessment and beginning of treatment) has been shown to be a critical phase of relationship building between parents and nursing staff (Scharer, 2000). For parents, no matter what their expectations, on arrival, the admission of their child to a psychiatric unit is experienced as stressful (this is explored later in the literature review). The admission phase can set the tone for the entire hospitalisation; nurses are assessing the child's problems and the family dynamics during the admission phase and parents are gathering information about the unit and its routines and begin to know the staff. Scharer (1999) reports that negative expectations about psychiatric hospitalisation can be overcome relatively quickly by a positive experience during admission. Research suggests a number of key issues (Scharer, 1999, 2000, 2002): both parents and nurses have a set of expectations that influence the quality of relationship in the admission phase, nurses usually expect parents to be invested in their child, involved in the treatment, and open to learning and beginning to understand the need for change in their own, as well as their child's behaviour. In addition, parents are afraid of being judged or blamed, are hoping for a change in their child and for support and assistance from the treatment team. Sometimes parents arrive with negative expectations due to previous poor experiences with mental health care professionals. This poses a greater challenge to the treatment team. Both parents and nurses had difficulties initially if their expectations were not met. Routines of the unit (e.g. staff rotations) also impact significantly on the admission experience (Scharer, 1999, 2000). A thoughtfully handled admission forms the foundation for engagement.

2.5.2. b) The working phase

The task of this phase is to develop a relationship that allows both the parents and nursing team to work together to understand the child's problems and to develop techniques for managing problem behaviours which the child displays. Scharer (1999) explains that the tasks of the working phase are managed through patterns of interactions: engagement, disengagement, or failure to engage. Engagement is understood as a process through which the parent and the nurse becoming involved and emotionally connected with each other. For engagement to proceed both members need to be ready and willing to interact with one another. It is harder for nurses to engage with parents who do not want to learn (Scharer, 1999). Engagement can occur between the parent and some staff members but not necessarily with all staff. Engagement may also be influenced by a variety of factors such as staffing patterns, parent work schedules, scheduling of visiting hours as well as the perception of each other's personality traits. Such personality traits can result in a 'good fit' between parent and nurse while at other times just relating to one another could take a great deal of effort. It is noteworthy that whilst Scharer (1999, 2000) does speak of the need for individuality and that engagement strategies have to be specific to the parents, she does not consider the impact of language, culture, gender, race and socio-economic status on the ease or difficulty experienced in relationship building between parents and members of the clinical team.

Scharer (1999) also reports on what she found to be a rare occurrence: the development of a working alliance. This alliance developed from engagement when there was an extended duration to the relationship or an unusual intensity in a positive relationship. In South Africa, when admission is generally longer than in the United States, there are more opportunities for this

working alliance to develop. Sustained interaction was a prerequisite for engagement and included both physical presence and emotional availability of both parents and nurses to interact.

Disengagement occurred when there was some event that caused disruption in the relationship between parent and nurse. This could be one sided or mutual and deliberate or circumstantial, such as, a vacation taken by the nurse, illness, emotional upset or decreased staffing. However, Scharer (1999) stresses that disengagement can be temporary; efforts by either parent or nurse can lead to re-engagement. Also, Scharer (1999) suggests that the notion of a working alliance is the high end of a continuum that begins with engagement. This is a useful operationalisation of the concept of the quality of relationship that can exist between staff and parents, and especially as parental involvement is now considered necessary for a successful outcome to a child's hospitalisation (Jemerin & Philips, 1988).

Although the above research takes steps towards an understanding of the notion of therapeutic alliance in child psychiatry, it also highlights the difficulties in conceptualising what the term means and the range in degrees of alliance/involvement. In addition, Scharer (1999) argues that perhaps it is not always necessary to have parental engagement, as disengagement can at times be therapeutic. There can be little doubt, however, that in order for an alliance to exist between parents and staff, engagement has to be established and encouraged. It is therefore useful to consider which factors contribute to parental involvement as well as the challenges facing parents of psychiatrically ill children.

2.6. The Family of a Psychiatrically Ill Child

2.6.1. Family involvement

As family relationships play a central role in the aetiology and course of psychiatric problems in childhood (Mathijssen, Koot, Verhulst, De Bryn, & Oud, 1998; Lask & Maynerd, 1998) it is considered essential for the family be involved in the treatment of the child. In addition, the child is more often than not placed back with their family and thus work with the family system is essential if change is to be sustainable and effective. Some units in the United Kingdom and the Netherlands go as far as admitting whole or part families during a child's admission (Jacobs & Green, 1998).

There are many factors that can contribute to difficulties in ensuring the involvement of parents:

- Issues of culture and power: Families may make rapid assumptions about the capacity of a unit to understand their positions and listen to their voices. Units that have a staff reflecting the cultural diversity of potential referrals are at an advantage. Staff may also make assumptions about families based on race, class or gender which can influence the quality of the relationship.
- Staff often have limited opportunities to meet with family members because of busy schedules and shift work. This leads to staff not connecting with parents.
- The distance of the unit from the family home can be a significant problem for parents of children who live far away from the unit.
- The admission itself may be seen as a solution by the family. They may perceive the duration of the admission as a relief and wait for the return of their 'cured' child.

- Admission can place the burden of change on the child, whose best efforts may be counteracted by what is happening within their family.

Lask & Maynerd (1998)

Child psychiatric units usually offer a variety of opportunities for the parents to become involved with the unit e.g. parent's support group, family therapy sessions and several visiting hours during the week (Sharer, 2002). Whatever the contact is between staff and parents, there is little doubt that every bit of interaction can influence the parent's attitudes towards the unit. As Lask & Maynerd (1998, p.79) state: "All communications with the unit affect engagement". Communication assists the family in developing trust in the unit. Lask & Maynerd (1988) also make the following suggestions: a pleasant welcome, comfortable surroundings and clear information can go a long way in encouraging a positive working relationship between the family and the unit. In addition, staff members have to develop and maintain interest and respect for both family strengths and constraints. Constant feedback and the sharing of information are also essential. The family have a right to know the plan of treatment for their child and the intended duration of admission.

2.6.2. The needs of parents of psychiatrically ill children

Admitting a child to a psychiatric in-patient unit can be a very traumatic experience for the parent. Not only are parents giving over care of their child, but they are also acknowledging that the difficulties are so severe that they can no longer manage them and that hospitalisation is required to stabilise the child's behaviour during the crisis (Harper & Cotton, 1991). Delaney & Engels-Scianna (1996) note that most parents hope that the admission will result in specific behavioural changes and usually admit their child only after a pivotal event.

On admission parents often fear being blamed for the child's behaviour or being 'exposed' as a bad parent. However, literature is scarce on how parents of psychiatrically ill children make sense of the admission and treatment of their child. There is also very little research on the effects of parent blaming by the staff of an in-patient unit, however subtle, on parent involvement during the child's hospitalisation (Sharer, 1999). The previously mentioned legacy of 'parent as pathogen' continues to influence unit's philosophies, which then set limits on parent-child contact and thus also limits parent staff contact. Involving the parents in the actual milieu is an issue that remains controversial. In most cases, children are placed back into their original family homes. If this is so, helping parents learn more effective parenting techniques can be seen as a practical intervention with long term benefits. Some authors such as Scharer (2002), Delaney (1992) and Violand & Williams (1994) argue for greater parental involvement in the milieu as a way to teach parents more effective management of their children. However, each case needs to be assessed individually. Such parenting advice and training may only be appropriate in certain cases. There remains a need to be cognisant of the interplay between child and parent that may maintain pathology.

Scharer (2002) investigated what parents of mentally ill children need and want from mental health professionals. These specific needs and wants, during the psychiatric hospitalisation of a child, have not previously been discussed in the literature. This is one of the few studies that looks at child psychiatric hospitalisation from a parental perspective; others include Delaney & Engels-Scianna (1996); Plunkett (1984); Evrinomy, Griffin & Brough (2000) and the previously discussed Scharer (1999). The Scharer (2002) study is of particular importance for the current research, as it mentions specific examples of what can contribute to parents feeling alienated

from their child's admission and treatment. This in turn impacts on the therapeutic alliance between unit and parent. Results from the study can be summarized as follows:

- Parents need information relating to their child's care, for example, written material on their child's diagnosis.
- A detailed account on the running of the unit received both verbally and in writing is needed by parents; it is important for parents to know who does what. Written material was requested as the stress experienced by parents during the initial phases of admission made it difficult to remember everything that they were told.
- The staff should volunteer information, as many parents reported not knowing what questions to ask. Parents also reported feeling resistance from the staff when they asked specific questions, especially around issues of medication.
- Parents felt that access to the psychiatrists treating their child was limited.
- Parents needed instrumental support in the form of lodging offered close by for parents who live some distance from the hospital, more liberal visiting hours and telephone access, and a telephone call prior to the visit to let them know what the child needs.
- The bare and cold physical environment was distressing to many parents: "While décor might not seem to be a big issue to professionals, to parents it symbolises the care the child will receive" (Scharer, 2002, p.636).
- Parents' needs include not only receiving support themselves, but also ensuring that their child's emotional, physical and daily living needs are being met. Parents want staff members to demonstrate caring toward the child as well as to the parents.
- Parents enjoyed having access to other parents in order to share their experiences and receive and offer support.

- Perceived mismanagement of any child eroded their trust in their staff member's ability to care for their child successfully.

Such findings may be of great value to the staff of a child in-patient psychiatric unit. However, the effectiveness and impact of increased parental access and contact during treatment has yet to be investigated and so unrestricted parental access and contact should be approached with caution. The literature suggests that instrumental support is important for parents of children admitted to a child in-patient psychiatric unit. Whilst recognising the severe economic limitations within South Africa, the need for instrumental support such as lodging, cannot be ignored. Such instrumental support may be essential in fostering and building parental alliance, a factor known to be associated with a positive outcome.

The first half of this literature review has explored the complexities inherent in child in-patient psychiatry from both a staff and family perspective. Both staff and parents have different needs and expectations from each other. The needs expressed within this relationship may offer an important key to understanding the subtle dynamics of the therapeutic alliance. The process of relationship building between staff and parents is likely to contain and express many of the complexities of the broader social environment. By looking at the relationship through a psychoanalytic lens it may be possible to gain a deeper level of understanding. The second half of the literature review considers the establishment and maintenance of therapeutic alliance from a psychoanalytic perspective.

2.7. The Psychoanalytic Framework

As Freud and others discovered, there are aspects of human mental life that, while remaining hidden, nevertheless influence conscious processes (Halton, 1994). The object of psychoanalysis has been to read the underlying meaning from its surface manifestation, however, the way in which this has been conceptualised has changed considerably over the last few decades (Gibson, 2002). Originally Freud felt that the unconscious was elusive, only accessible through dreams and free association. Melanie Klein saw unconscious phantasy as the mental expression of instinct. Klein regarded the first mental processes as the earliest beginnings of phantasies (Hinshelwood, 1991). In the mental development of the infant, however, phantasy also soon becomes a means of defence against anxieties, a means of inhibiting and controlling instinctual urges and an expression of reparative wishes as well (Hinshelwood, 1991). In this way phantasies may contain needs that cannot be expressed openly or reflect an internal attempt to protect oneself from overwhelming anxiety. Authors such as Segal (1995) and Mitchell (1986) developed the notion of phantasy that allows for the unconscious to be less elusive than Freud first conceptualised (Gibson, 2002). Thus, unconscious meaning is seen as running just below the surface of conscious experience, creating an ongoing narrative through which new experiences may be interpreted. New experiences, however harmless they appear, can be overlaid by existing phanstasies that in turn contribute to the experience of current relationships (Gibson, 2002).

The existence of an unconscious, both organizationally and individually, is central to the argument developed in this thesis. A psychoanalytic perspective is useful in terms of understanding relationships that develop between staff and parents of psychiatrically ill children. Both staff and parents have conscious and unconscious anxieties that may influence the way they relate to one another.

2.7.1. Parents and unconscious phanstasies

Fundamental to psycho-analysis is the anxiety-defence model, according to which an individual has conscious and unconscious anxieties and conflicts which are dealt with by developing psychological defence mechanisms (Hinshelwood & Skogstad, 2000). Staff need to be aware that parents' internal phantasies may result in defensive patterns that influence the nature of the parents' interaction with the unit. Parents may carry a number of both unconscious and conscious phantasies. Staff need to be aware that these phantasies are often highly specific and unique to each family, given such factors as the nature of the difficulties, the family history, the nature of the parental relationship, and the presence or absence of siblings. One example of a phantasy may be the belief that it is their (the parent's) inadequacy that has caused their child's illness. This phantasy may inform the expectations that parents have about the unit and their hopes for their child. Parents may, therefore, be caught in a state of ambivalence: whilst a parent may consciously wish for the professionals to 'cure' their child, such a 'cure' may confirm their underlying phantasy that the child had to be removed from their care in order to get better. Parents then feel grateful to the unit for any improvements their child is making, but may, at the same time, experience rage towards both themselves and the unit for confirming the underlying phantasy that they are indeed inadequate (Green and Jones, 1998). Staff need to be mindful that parents can develop different ways of coping with such ambivalence. For example, they may try and avoid contact with the unit or narrate stories that demonstrate how 'sick' the child remains. Thus it is essential that staff are aware of possible underlying phantasies that can influence the communication between parents and staff.

2.7.2. Parents and the trauma of living with a psychiatrically ill child

Parents of psychiatrically ill children are faced with many issues, both emotional and instrumental. Gudmundsson & Tomasson (2002) state that the mental health of parents and their quality of life is likely to be affected when a child in the family has a psychiatric disorder. They conclude that mothers of children with mental disorders have poor quality of life, and high prevalence of mental disorders and thus child psychiatric clinics need to ensure that mothers receive appropriate care along with the child.

Whilst children are usually admitted to a psychiatric ward following a major crisis in the life of the family, Klauber (1998) argues that daily life with a psychiatrically ill child, at whatever stage of treatment, can be compared to living in a state of constant trauma. Klauber (1998) suggests that living with a disturbed child is extremely traumatising to a family and may result in post – traumatic stress disorder in the parents. Klauber argues that the difficulty of having a child with a psychiatric illness and managing that on a daily basis is as traumatising as a major public disaster. She suggests that the impact of trauma and post-traumatic stress on the parents' capacity to parent and on their ability to work closely with a professional is very significant.

Since mental health professionals hold a great deal of power in diagnosing and suggesting a management plan for their psychiatrically ill child, parents may become resistant to contact with professionals. Diagnosis can be profoundly shocking for parents and (in the transference) may lead to the professionals being perceived as the ones who make unconscious fears and anxieties real and bring these into the parental consciousness (Klauber, 1998). The professional may become identified with the trauma and as such can become hated, abandoned, avoided (sessions missed) or treated with sudden hostility. Thus the professionals may come to concretely represent

the re-experiencing of the trauma itself. It is also likely that, like any victims of tragic events suffering from post-traumatic stress, parents will resort to projective identification as a means of ridding themselves of anxiety and terror and as a means of communicating their unbearable feelings and experiences in a primitive, non verbal way (Klauber, 1998). This can result in staff experiencing powerful emotions towards parents that may, if explored, provide insights into the emotional life of both the parents and professionals involved in the child's care.

2.7.3. Staff and working with a traumatised family

Close examination by staff of the transference and counter-transference between them and the parents of the ill child is essential, as, often in the face of projected anxiety, hostility and despair, it is difficult for staff to avoid being drawn into hasty and judgmental conclusions. Countertransference is, in its original Freudian sense, an impediment to understanding the parent's pathology when ones' own issues obscures it (Hinshelwood & Skogstad, 2000).

Tischler (1979) suggests that mental health professionals may not recognise their own bias in believing parents to be responsible for the child's illness. Workers may also not acknowledge their own emotional difficulties, which could include an excessive identification with the suffering child, mother or father, which may lead to paralysing pity, condemnation or both (Klauber, 1998). Such over identification can cloud the service provider's judgment.

Klauber (1998) also warns that what staff witness in the first meetings with the family is all too often used as evidence for a diagnosis of the aetiology of the disturbance, rather than considering that they are observing the consequences of the trauma and loss which is a result of living with a psychiatrically ill child. Staff often perceive parents who are unable to give a clear detailed

history as being in some way inadequate, however, the ability to recall events in detail may be severely disturbed in traumatised parents (Herman, 2001). Thinking about parents in this way may help professionals to be less judgemental and more able to empathically engage with the painful experience of being a parent of a psychiatrically ill child.

If contact with the unit is experienced by parents as re-traumatising, this repetition may, if properly managed, provide the parents with an opportunity for reflection and containment, and, within a therapeutic setting, allow for the establishment of a deeper understanding of what the parents are trying to manage. Gibson (2002, p. 40) states: "where there is sufficient containment offered by a relationship, new experiences may be able to mediate the phantasy world, allowing for needs and anxieties to be openly expressed and new relationships to be developed along different patterns." Hinshelwood & Skogstad (2000) suggest that institutions pursue unconscious tasks alongside their conscious ones, and those affect both their efficiency and the degree of stress experienced by the staff. Thus, staff have to constantly reflect on their own unconscious phantasies and those of the parents, and respond in a way that can be therapeutically beneficial.

There is a need on the part of staff for receptive flexibility. In order to consider the unconscious aspects evoked by this difficult and evocative area of work, staff are likely to need support and ongoing training (Green, 1998). Staff groups and supervision are a method of addressing and recognizing the unconscious aspects of the work.

2.8. The Child In-patient Psychiatric Unit: Organizational Dynamics and Challenges

In addition to the unconscious life of parents and staff, there is also an argument for considering the unconscious aspects of organisations that may influence service delivery.

2.8.1. Psychodynamic theory: Bion and the importance of containment

Psychodynamic theory would argue that organizations have an unconscious life that informs the quality of services delivered. Much organizational dynamic theory has its roots in Bion's theory of group functioning. Gibson (2002) summarised Bion's early contributions to group theory as follows: firstly, he introduced the notion that groups have a powerful unconscious life that, if unduly influenced by anxieties, can preoccupy the group to the exclusion of its real task (Bion, 1961; Gibson, 2002). In this way groups function on two distinct levels: one level involves a rational task-orientated focus aimed at addressing the work of the group, called the primary task. The other level, termed the basic assumption level, entails the non-reality focused activity motivated by unconscious processes utilised to evade a painful reality. Secondly, Bion stressed the repeated assertion of the significance of processes of identification that create shared emotional experiences between group members. Bion saw this as an innate need of individuals (Gibson, 2002). Thirdly, Bion's theory also asserts that individuals are fundamentally always members of groups.

Bion's later work focuses on knowledge. Knowledge for Bion is produced through processes of digestion and construction, in which thought, or knowing only becomes possible through a relationship (Parker, 1977 as cited in Gibson, 2002). The baby's ability to think and learn is provided through the mother's capacity to take in the raw sensations of the baby and give meaning to them. The terms 'container' and 'contained' describe the way in which the infant's experience requires the active holding of the mother, which includes her capacity to think (Gibson, 2002). When this theory is transposed onto an organisational group it is argued that the ability to contain (to think and hold onto the primary task of the group) in the face of extreme anxiety and stress is central to the effective functioning of the organisation. In a child psychiatric

unit, children (and their parents) can communicate their distress in very volatile non - verbal ways that requires a great deal of consistent containment and reflection by staff:

> These children need "containment", they need to feel their emotions can be tolerated, can be understood and can be put into words, that their rage will not destroy the organizations and their neediness and longing will not provoke rejection
>
> (Trowell, 1995, p.187)

2.8.2. Anxieties and defences

Effective containment by staff requires the acknowledgement of unconscious anxieties and the defences which are enacted by individual staff members and the organisational culture as a whole. A child psychiatric unit that is unable to think and thus reflect on its own processes, runs the risk of employing a defence that disavows its own anxiety and consequent acting out. As Parker (1977, as cited in Gibson, 2002) states, institutions may function according to the 'minus K', which is motivated by an unconscious desire not to know. The evacuation of such knowledge can operate as a shared defence against threatening information or ideas. Other defences can obstruct contact with reality, and in this way damage staff and hinder the organization's functioning.

Jaques (1953, as cited in Hinshelwood & Skogstad, 2000) uses Kleinian theory to illustrate how anxieties of a paranoid or depressive nature influence organizational defences. He discusses the function of splitting, projection and the use of manic defences, denial and idealization to ward off organizational anxieties. However, not all defences are negative; in some instances they may

enable the staff to cope with stress; for example, humour, may be seen as a mature defence that is often a positive way to relieve tension.

2.8.3. The development of organisational anxieties and defences

Individual anxieties and defences, which are influenced by the individual personalities of the staff and the nature of the work, form part of the organisational dynamics of a child in-patient psychiatric unit. The development of anxiety and defences in an organisation is a complex process. Within organizations, individuals will experience anxieties from various sources. Some will be work specific anxieties and some individual (Hinshelwood & Skogstad, 2000). These anxieties become part of the organisational dynamics. Hinshelwood (1989) describes how people unconsciously use their social network as a way of transferring difficult feelings and parts of themselves onto others. Feeling states and emotional experiences become shared and there is diffusion in the boundary between the social network and person (Gibson, 2002). Hinshelwood & Skogstad (2000) suggests that there is a tendency for people to be drawn into particular fields as a result of similar kinds of defences. Jaques (1953, as cited in Hinshelwood & Skogstad, 2000) proposed that a social system can support the individual's own psychological defences. His core idea is that individuals can unconsciously use the social system to help defend against their anxieties. The defensiveness becomes part of the social system or organisational system, manifesting in shared understanding and practices that determines how the work is undertaken (Gibson, 2002).

During the 1960's, Menzies Lyth's explored how the nursing profession is structured in such a way as to avoid anxieties inherent in the job (Menzies Lyth, 1988). Her work is still acknowledged as the seminal work in the psychoanalytic understanding of nursing. The rituals

and practices observed in the nursing profession are designed to defend against anxieties inherent in their work. This way of working assists in keeping difficult feelings at bay. However, emotional distance from patients can also result in nurses feeling emotionally cut off from their primary motivation of being an effective caregiver. Menzies Lyth (1988) uses the notion of 'culture' as a means to bridge the psyche and the social. Thus, the organizational culture serves as a defence against anxiety provoked by both the nature of the work and the predisposition of the individuals within the organization.

Hinshelwood & Skogstad (2000) further explore the notion of the defensive culture of organizational life by focusing on one specific relevant element of culture: a set of unconscious assumptions, attitudes and beliefs about the work tasks and how to perform them. These unconscious elements are held collectively within the team of staff which leads to characteristic work practices, but also to less tangible phenomena which can best be described as the 'emotional atmosphere' (Hinshelwood & Skogstad, 2000). Although unconscious, the "emotional atmosphere" has a powerful effect on how people think and engage with their tasks. It is arguable that these are the unconscious processes that underlie the previously discussed therapeutic variables namely, ward atmosphere and therapeutic alliance. It illustrates the complexities in understanding the effect of such variables when attempting to assess outcome in child psychiatric in-patient treatment.

2.8.4. The impact of the nature of the work

Anxieties and defences amongst staff are likely to be influenced by the fact that child in-patient psychiatric units are seen as the 'intensive care' of child mental health (Jacobs & Green, 1998). Such units may be seen by both staff, referring professionals and families as the 'last resort' and

may often be confronted with problems that seem to have no solutions. This has implications for the morale and functioning of the staff. Under this kind of stress staff may feel demoralised and parent blaming can become prolific (Baker, Heller, Blancher & Pfeiffer, 1995). In order to counteract this, staff have to constantly consciously strive to keep the peer culture therapeutic and to avoid what can become rapid shifts into anti-therapeutic dynamics (Green & Jones, 1998).

In addition to the challenges of working in a psychiatric unit, there are also specific difficulties inherent in working with children. Mawson (1994) refers to the anxieties that arise about the extent or permanence of damage inherent in children who are admitted to in-patient psychiatric hospitals. The dependency of children places a heavy burden of responsibility on the adults who care for them (Mawson, 1994). This burden may be strongly informed by overwhelming feelings of inadequacy elicited by working with damaged children. Much like parents who cannot acknowledge their wish for their child to remain ill for fear of what their recovery in the unit may suggest about themselves as parents, staff may not be able to face their own feelings of inadequacy. Such feelings may be denied or projected onto others because it is too unbearable for the staff to consciously acknowledge and contain these feelings themselves. Thus staff may blame parents or other staff members for the child's failure to get better. As Green (1998, p. 183) points out; "Unresolved conflicts between members of the staff group can be enacted in relationship with the children".

Working with psychiatrically ill children and their families requires a great deal of understanding, strength and constant self-reflection. A psychoanalytic framework may provide staff with a tool to explore the reasons underlying certain behaviours that occur both with the staff and the families. An understanding of the unconscious aspects of communication between staff and parents can assist in preventing a build up of anxiety, which, if left unchecked, may result in

acting out behaviour such as missing sessions, parent blaming and hostility towards a specific staff member. This behaviour is counter-therapeutic and detrimental to the treatment of the child. However, if such behaviour can be seen through a psychoanalytic lens, it may illuminate the underlying phanstasies inherent in both staff and parents, thereby providing a deeper, more therapeutic understanding of the case.

2.9. Conclusion

This literature review has highlighted the complexities evident in in-patient child psychiatry. The current issues facing in-patient child psychiatry were informed by the historical context of debates such as community based versus in-hospital care. Research into the effectiveness of in-patient treatment will remain crucial as a means to motivate for the high cost, low volume nature of child in-patient psychiatric units. This is especially true in the current South African context, which is characterised by scarce resources. In addition, the literature review considered the family of psychiatrically ill children and the specific needs that parents of these children may face. A psychoanalytic perspective of both staff and parents was considered in order to facilitate a deeper understanding of the underlying emotions inherent in living with and treating children with psychiatric illnesses. The interaction between staff, organizational and parent phantasies was central to the discussion and it was suggested that this would allow for a deeper understanding of the unconscious mechanisms that can influence family engagement. The next section of the thesis explores the utilisation of a qualitative methodological framework, which, it is argued, enables this study to explore factors that lie outside of operational measures, but which nonetheless foster or hinder therapeutic alliance between parents and staff of a child psychiatric in-patient unit.

CHAPTER THREE

3. METHODOLOGY

3.1. Introduction

This chapter locates the research in the context of the T.L.C. The T.L.C's procedures are briefly outlined as a means to gain an understanding of the functioning of the unit. Following this, my position as both a previous volunteer at the T.L.C and as a training clinical psychologist are explored. This leads into a brief outline of the aims of the thesis and an explanation as to why the child's perspective is excluded in the current research. Within the qualitative framework, use of the case study method, semi-structured interviews and participant observation as research tools are explored. Following this, the procedures undertaken with regards to data collection and analysis are explained. Finally the chapter concludes with a discussion of relevant ethical considerations.

3.2. The Research Context: The Therapeutic Learning Centre

Situated on a satellite campus of the Red Cross Children's Hospital in Cape Town, the TLC started as a day-patient unit in 1975. The intention was to make a facility available, to the greater Cape Town area, for the assessment and short-term treatment of children who, because of serious maladjustment, could not manage in school (Robertson and Pikholz, 1988). Prior to this, children had to be admitted to medical wards, institutions for the mentally handicapped or adult psychiatric hospitals, environments that are not appropriate and possibly harmful for children. The in-patient facility that was opened in 1990, amalgamated with the day-patient unit in 1992. Currently, the T.L.C admits both day and in-patients. The unit is serviced by a multidisciplinary team (including a teacher and an occupational therapist), and caters for both assessment (between

five and eight weeks) and treatment (six to twelve months) of psychiatrically ill children. The unit is structured around the normalizing routine of a school programme and adopts a cognitive behavioral treatment approach within a milieu environment. Although the techniques utilised in the unit are behavioural, the staff employ a psychodynamic understanding of the cases. The teacher at the T.L.C is required to teach a range of children, at varying educational levels as well as children who may have specific learning disabilities. It is a very difficult job evident by the fact that, in the past, the T.L.C had been through a number of teachers in a short period of time. The unit can accommodate up to eleven patients at any one time, six of whom can be in-patients (de Jager and Nel, 1999). The patients range in age from six to twelve years.

Staff groups take place weekly, and are facilitated by an outside consultant. All staff are provided with weekly supervision by either the unit's clinical psychologist or psychiatrist. In addition to ward rounds, which take place weekly, there is a weekly 'goal meeting' that addresses the behavioural goals of specific children in the unit. Each child is presented at a multi-disciplinary case conference once a term. At the case conference, issues regarding diagnosis, treatment and management of the child are discussed. After each case conference a feedback meeting is held between the staff and parents of the child, facilitated by the psychologist.

In addition, the patient's parents are expected to attend weekly sessions with the social worker. Currently, in the absence of the social worker, the clinical psychologist functions as the social worker for the unit. The parents are also encouraged to attend a parent support group that takes place twice a term. Two nurses from the unit facilitate these groups.

Each case at the T.L.C is assigned a 'special nurse'. Although all nurses are involved with the children and take turns with duties in the ward, the 'special nurse's' role is to form a close and

meaningful relationship with their assigned child. They take the child for 'special time' usually once a week for an hour. The time can be spent doing a variety of activities from play therapy to a walk in the park. The special nurse also tends to have a closer relationship with the family of the child.

In addition to full-time qualified staff, the T.L.C sometimes utilizes volunteers in the unit. The volunteers usually hold an Honours degree in Psychology and are volunteering in order to gain practical experience before applying to a Clinical Psychology Masters Programme. I was a volunteer at the TLC for the duration of 2001 and assisted with duties both in the ward and with formulating the proposal for the quantitative study. This experience placed me in a good position to undertake the current research, having provided me with both knowledge of the unit and an understanding of the proposed research the unit still wishes to undertake.

3.3. Research Aims

In developing a research question, it was felt by both the T.L.C clinical psychologist and my own supervisor that a master's thesis addressing the suggestions raised by the UCT research council would be beneficial to the T.L.C. Thus this study sought to address the two major themes which the U.C.T research committee felt the quantitative research proposal failed to consider:

1. How do parents experience the admission and treatment of their child to a psychiatric in-patient unit?
2. What fosters or hinders therapeutic alliance in child in-patient psychiatry?

3.3.1. The exclusion of the child's perspective

The two aims of this study do not incorporate a consideration of the child's perspective on their own admission and treatment. Green and Kroll's (1998) family engagement questionnaire has a separate section to address the alliance between the staff and the child. However, the questionnaire is completed by staff and does not allow for the child's perspective. Although this study attempts to gain insights into the families of psychiatrically ill children, a decision was made to exclude the child's perspective. This decision was based upon my experience as a volunteer in the unit. It was felt that interviewing children about their feelings towards staff whilst they remain in-patients might create difficulties within the ward. It was my concern that staff might feel that it could undermine the trust relationship they work so hard in building and maintaining with the children. In this way, interviewing the child directly may have interfered with the therapeutic process underway. Furthermore, obtaining permission from parents to interview the child would also have to be gained. Parents might see such a request as an additional burden for their child who is already experiencing a great deal of distress.

There is little doubt that the way the child feels about the unit can influence the parental perspective on both the treatment of their child and their beliefs about the unit's abilities in general. However, the aim of this research was primarily to gain a parental perspective, exploring the process from the child's perspective would be another research question on its own.

3.4. The Researcher as a Training Clinical Psychologist

Although this thesis requires me to be a researcher, I am also a trainee psychologist currently completing my internship year. I am growing in understanding of unconscious processes as well as developing my clinical skills to contain overwhelming emotion. My intention in the research

process was to explore the complexities inherent in a child in-patient psychiatric unit. Thus it is hoped that my training as a clinical psychologist assists my ability to look beneath the surface conversations and procedures to the unconscious communication. Research in clinical settings is a difficult undertaking (Riddle, 1989). Often clinicians fear that research will overlook the nuances of process in therapeutic intervention and that the research may disrupt carefully balanced dynamics of a therapeutic relationship (Hodges, 1990). In addition, there is also a concern that research can oversimplify the process of a therapeutic intervention, in order to identify effective procedures and outcomes (Fonagy and Target, 1994). This is the concern raised with regards to the T.L.C's proposed quantitative research on the impact of therapeutic alliance on health gain, during a child's in-patient admission at a psychiatric unit. Thus, as a trainee clinical psychologist with the specific intention of focusing on the less orderly and unconscious aspects of therapeutic alliance, a qualitative paradigm was considered to be most suitable to the current study.

3.5. The Qualitative Methodological Paradigm

There are additional reasons why a qualitative paradigm is best suited to the current study. This study aims to describe the experience of having a child in an in-patient psychiatric unit from the perspective of the parent. Miles and Huberman (1994) argue that qualitative analysis does this by providing a complete and detailed description which allows for an understanding of an individual's experience of a process. Babbie and Mouton (2001) refer to the importance of understanding the individual's own sense of being in the world and their behaviour and feelings in terms of their own beliefs, history and social context. The research also aims to explore the dynamics inherent in therapeutic alliance between staff and parents of a child in-patient

psychiatric unit. Qualitative research enables such exploration and provides an opportunity to probe the dynamics of relationships between people and between people and systems.

The current study also aims to inform the T.L.C's proposed quantitative study. Barbour (1999) refers to the possibility of qualitative data to enhance the quality of quantitative data by identifying relevant variables and themes for investigation, giving explanations for anomalous findings, generating hypotheses and research questions and providing insights into the process of knowledge production. Though quantitative data provides an excellent opportunity to determine how variables are related to other variables for large numbers of people, it provides little in the way of understanding why these relationships co-exist (Miles, & Huberman, 1994).

3.5.1. Reflexivity

Qualitative research uses the reality of the researcher's subjectivity and encourages the researcher to develop an empathic understanding (Glesne & Peshkin, 1992). Marshall & Rossman (1980) argue that 'objective' scientists, by coding and standardising may destroy valuable data while imposing their world on the subjects. However, qualitative researchers who lack self-consciousness or self-reflection may be accused of not understanding the complexities of the research process, or the impact of their presence on both the results and process.

Stake (2000) notes that a case study relies on some sort of narrative to provide it with structure and this inevitably reflects something of the researcher's choices about what to include and how. Swartz (1999) warns about writing clinical material in a way that creates the illusion of 'truth'. Thus, power plays a central role, as the clinicians/researcher decides how to define and mould the client's reality. However, in qualitative research the aim is to explore experiences rather than

define objective truth. People's experiences are made up of layered 'stories' rather than facts (Gibson, 2002).

The need for reflexivity is crucial to effective qualitative research. The aim is not to be objective, but rather to be consciously aware of how the researcher's own subjectivity interacts with the participant's subjectivity and how this informs the results (Kvale, 1996; Stake, 2000). This thesis involves the search for meaning within the material available as well as the capacity to reflect on the emotional investment that may influence interpretation by the researcher. The field of inter-subjective psychology provides insights into the role of the therapist in the therapeutic process (Gibson, 2002). Such insights are useful when examining reflexivity in the researcher. The therapist is seen as observing from within rather than from outside of the intersubjective field (Stolorow and Atwood, 1992). Within this framework, the researcher is seen as part of the research, whose presence and reactions are vital to the process. Self-reflection is crucial to a researcher's ability to locate the meanings and assumptions they bring to the research process. The object of this self-scrutiny is not just to recognise the researcher's involvement in the process but also to learn from it (Gibson, 2002). One must take into account the researcher's position and theory as well as the unconscious emotional dynamics between the researcher and participants (Hollway and Jefferson, 2000; Gibson, 2002). My own subjectivity in relation to this research is discussed later in this chapter.

Within the qualitative framework, use of the case study method, semi-structured interviews and participant observation as research tools were employed.

3.5.2. The case study method

The case study as a method of presenting insights and understandings about clinical work is well established within the psychoanalytic tradition (Gibson, 2002). Yin (1994) describes case studies as a way to retain a real sense of the person or people who are being spoken about. In this research the case study method enabled the researcher to gain a rich amount of data from two separate cases. This data allowed the research to draw comparisons and to elucidate the therapeutic process by highlighting differences and commonalities.

The cases were chosen with the assistance of the clinical psychologist at the T.L.C. The first case was identified as suitable because the child presented with a specific issue, selective mutism. Such a specific difficulty suggested a focused and intense intervention. The psychologist also indicated that the child would possibly only be admitted for one term. Whilst the family was apprehensive about the admission itself, they were trusting of the expertise offered by the T.L.C and referring doctor. The case proved to be manageable for the staff, with few stresses experienced. After completing the interviews it was felt that the case presented a rather one-sided view of the T.L.C. Although it was very useful to understand why such a case proved to be so manageable for the staff, it was felt that the study would benefit from following a case that was expected to be more stressful for the unit. Thus, an additional case was selected at the end of 2003 that was likely to be a great deal more complex. The two families are described in more detail in the results section.

3.5.3. The Interview as a research tool

Individual semi-structured interviews (appendix A to D) were conducted with both parents and staff for each case study. The unit staff that were interviewed included the head psychologist (due to the absence of the social worker) and special nurse for the child. Interview questions were formulated by drawing on issues highlighted in the literature and from what I experienced as a volunteer in the unit. Particular emphasis was placed on addressing aspects thought to be crucial in relationship building and on asking both staff and parents similar questions to assess whether their respective answers corresponded. In addition, questions were also constructed to gain a clear understanding of a parental experience of the unit, an aspect clearly lacking in the literature. The interview schedule for the staff enquired about the staff's perceptions and experiences of the parents, as well as the effects of the respective cases on the unit.

As the research needed an in-depth understanding of individual experiences, semi-structured interviews provided the flexibility required to achieve this. The semi-structured interview method allows for the establishment of a relationship between the researcher and participant (Miller & Glassner, 1997). It allows for the interviewer to develop the participants' responses by guiding the questioning and clarifying the meaning of responses. According to Rubin & Rubin (1995) rapport is essential to the interviewing process as it allows participants to trust the interviewer and to provide rich and personal information. As the experiences of both families were so different, it was essential to track differences; the interview method allowed for such tracking.

The semi-structured format also allowed for the exploration of specific issues highlighted in the literature, whilst leaving the interview process open enough to allow the participant the freedom to include information s/he felt was pertinent but not directly elicited by the interview (Kvale,

1996). Attention was placed on the flow of the interview and the order of questions was not strictly followed. The schedule was used more as a guide to the interview and as a reminder of the important themes which needed to be explored. This allowed the participants to talk about issues they felt were more important to them, thus assisting in obtaining information which parents and staff perceive as crucial and relevant.

The semi-structured interview did, however, include specific questions that had to be answered. It was also guided by the researcher and probed into areas that were of specific interest to the study. This is unlike unstructured interviews that allow for participants to direct the conversation more freely. The interviews were conducted with parents who were coping with many difficult issues and with staff who also needed to reflect on their own assumptions and perceptions. There is a balance between guiding and controlling an interview. At times the researcher needed to be directive and controlling of the process. Mischler (1986) warns of how a controlling interviewer may leave the interviewee feeling disempowered. In an attempt to manage that sense of disempowerment an interviewee may become silent or withdrawn. In order to avoid this there was a conscious attempt to provide the parents and staff with a sense of the researcher's genuine interest and with the experience of being listened to by the interviewer. Corbin and Morse (2003) state that interviewees can feel empowered by telling their story. In this research both parents and staff appeared to welcome the opportunity to give their perspectives.

Gibson (2002, p.82) states that "…any researcher would need to recognise the way in which both participants and researchers may carry internalised aspects of their broader social world and act these out in relation to one another." Of particular interest, with reference to parents of psychiatrically ill children as well as the staff who care for these children, is the notion of the 'defended subject' (Hollway & Jefferson, 2000). Anxiety can play a major role in what

participants choose to say. I anticipated the following kinds of difficulties when approaching parents and staff: parents could feel that, just like the unit, I am there to explore how they failed as parents. This may, in turn, impact on their attitude and approach to the interview, thus, in order to mask or manage their anxiety, they may become defensive or overly compliant or enthusiastic. In turn, staff may feel exposed and suspicious about enquiry into their procedures or feelings towards parents. They may be resentful of the time it takes to conduct the interview. However, it was hoped that my own clinical therapeutic skills, such as affirmation and empathizing with both staff and parents, would allow for a calm and supportive environment during the interview process.

In-patient child psychiatry is an emotional arena. Corbin & Morse (2003) report that interviewees often reveal intimate and private material during interviews. The process of interviewing can also evoke intense emotions and result in the participants feeling uncontained and vulnerable. Being able to contain the emotions that arose as well as reflecting on the processes and context was a challenging task. I felt that my clinical training, understanding of the T.L.C and my previous experience as a volunteer with parents of psychiatrically ill children, enabled the building of good rapport throughout the research process.

3.5.4. Participant observation

In addition to the interview conducted, I also attended case conferences for both case studies. As stated earlier, the case conference is the multi-disciplinary forum for presentation of a particular child where issues regarding diagnosis, treatment and management are discussed. They are held once a term for each child. In the first case study the child was only admitted for a term and thus only one case conference was attended. The second case study was tracked for two terms of what

is likely to be a four-term admission plan, so two case conferences were attended for the second case. Attendance at the case conferences falls within a participant observation approach to data collection.

Participant observation is seen as a method that is conducive to studies of interpersonal group processes (Bogdan, 1972). Arguments in favour of this method include reliance on first-hand information, high face validity of data, and reliance on relatively simple and inexpensive methods. However, critiques of participant observation as a data-gathering technique include increased threat to the objectivity of the researcher, unsystematic gathering of data, reliance on subjective measurement, and possible observer effects (Winstein, 1982). Observer effect refers to the fact that behaviour may be altered merely by the realisation on the part of the participants that they are being observed. I was listening with an understanding of organisational defence mechanisms and an awareness of the possible influence my presence could have on the behaviour of the staff (i.e. observer effects). My intention in listening to the case conference was to ascertain the narrative that the staff developed with regards to the case. I was interested in observing if the various disciplines within the team had different understandings of the child and his/her family. I was also observing whether staff were able to express their opinions of the child, and how the team was engaging with the family.

3.6. Procedure

As stated previously the cases were chosen in consultation with the clinical psychologist of the T.L.C. A meeting was held in December, 2003 with the staff of the T.L.C, where the research was explained and discussed. Staff were welcoming of the research and were pleased that the research process would not add additional responsibilities to the staff. Informed consent was

obtained for both cases. A formal letter was given to the parents by the psychologist at the T.L.C. (Appendix E).

Interviews with the parents were conducted approximately four weeks after admission. The interviews were held in the family home, as I wanted to ensure the parents comfort and also ensure that I would be recognised as being separate from the T.L.C. Within the same week as the parent interviews, the psychologist at the T.L.C, as well as the special nurse in charge of the case were interviewed. After the child from the first case study was discharged, follow up interviews were conducted again with both staff and the family. For the first case, only the mother agreed to participate in the interview. The father suffers from a psychiatric condition and had limited interaction with the unit. The staff only engaged with the mother and so it felt acceptable to exclude the father during the interview process. For the second family the child is currently still an in-patient at the T.L.C. The duration of his treatment has yet to be finalized but it is likely that he will continue to be at the T.L.C till the end of 2004. Thus, follow up interviews were done six months after admission with both the family and staff. As the parents are divorced they were interviewed separately. All interviews and case conferences took between 60 and 90 minutes. They were tape recorded and labeled.

Table 1. Data Collection Dates

Case Study 1		**Case Study 2**	
Initial interview with mother	21 August 2003	Initial interview with father	9 February 2004
Initial interview with staff	26 August 2003	Initial interview with mother	12 February 2004
Case Conference	1 September 2003	Initial interview with staff	19 February 2004
Second interview with mother	23 October 2003	Case conference 1	23 February 2004
Second interview with staff	21 October 2003	Case conference 2	17 May 2004
		Second interview with father	20 August 2004
		Second interview with mother	27 August 2004
		Second interview with staff	23 August 2004

3.7. Data Analysis

A psychoanalytic perspective allows for a consideration of the researcher's own responses which are seen as being significant for the understanding of the process. This may be regarded as the equivalent of the clinical experience of counter-transference (Heiman, 1950 as cited in Gibson, 2002). My clinical skills were utilized when analysing feelings elicited in me during the interviews and in the writing up of the research. Gibson (2002) states that exploring such feelings can provide crucial insights. Throughout the data analysis, my reactions and feelings about the data obtained were explored and reflected upon. For example, during the process of listening to staff interviews I would at times feel irritated with the parents. This irritation helped me to understand the frustration that can arise when staff are trying to engage with parents.

Due to the bulk of the data gathered, the specific technique used in analysing the data was that of thematic analysis. Themes are identified by "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60). It is the researcher's task to assemble themes that emerge to form a comprehensive picture of the participants' collective experience. According to Garner (1991), a theme is a statement of meaning that (a) runs through all or most of the pertinent data, or (b) one in minority that carries heavy emotional or factual impact. Throughout the data analysis the themes that emerged were collected under the two main aims of the thesis:

1. How do parents experience the admission and treatment of their child to a psychiatric in-patient unit?

In order to address the first aim of the research the case studies were looked at as two separate entities. This was done as a means to gain a narrative of parental experience of the unit and to

explore the possible difficulties unique to each case and to compare commonalities inherent in caring for a psychiatrically ill child.

2. What fosters or hinders therapeutic alliance in child in-patient psychiatry?

The relationship between staff and parents was assessed from both a staff and a parental perspective. In addition to the parent interviews, data from staff interviews and case conferences were used to assess the staff's perspectives of the cases and their experiences with the families. In this way it was possible to ascertain when staff and parents opinions were congruent and when they differed. The general themes that emerged were ascribed labels such as 'expectations' and 'concerns about admission'. These labels were informed a great deal by the literature, but were also influenced by sentiments expressed by the participants. The results are presented separately for each case study, but within the narrative of the second case study, data from both cases are compared in order to explore general commonalities or differences that may influence the quality of the relationship between staff and parents. Direct quotations allow for the subjective expression of the core issues and processes to be communicated through the research. Thus, direct quotations will be used in the results section and are recorded verbatim, without any grammatical or stylistic corrections.

3.8. Ethical Considerations

Although this is the designated section on ethics, ethical issues are mentioned and raised throughout the thesis. The central belief throughout this work is that the patient is the ultimate benefactor. There is an unwavering hope that this type of research might improve patient care.

3.8.1. Confidentiality and informed consent

Written consent from parents was obtained for both cases being studied. As stated previously, the psychologist at the T.L.C first approached the parents on my behalf. On first contact with the family I enquired again if they would be willing to engage in the research process. The aim of the research and my position as a student was clearly explained. I also stated that I had previously been a volunteer at the T.L.C and had a clear understanding of the unit and its procedures.

It was explained to parents that staff would know which cases I was following, but that I would not be using their names in the research in order to protect their identities from readers outside of the T.L.C. The staff were also aware that although names were not to be used, their job descriptions would be included. The psychologist at the T.L.C gave full permission for the unit to be named. On discussion with the psychologist it was felt that the study would be used to benefit the unit, and that confidentiality would not be able to be secured (especially as only one child in-patient psychiatric unit exists in the Western Cape). When utilising a case study methodology, with a context of such a small group of parents, it is impossible to guarantee anonymity, however, the purpose of the research and the exact reporting of it were explained in detail to the families before both sets of interviews.

3.8.2. The impact of the research process

Gabbard (2000) highlights the tensions that result from the ethical requirement of gaining informed consent. He also suggests that informed consent from participants may influence ones findings. The staff were aware of which families I was tracking. Thus it is important to acknowledge the influence that such knowledge could have had on the relationship between the

staff and the family. I was concerned that staff would perhaps make more of an effort with the cases I was tracking or that parent's attention would be drawn to areas of the unit and staff they would not have ordinarily considered. However it is important to note that no overtly obvious behaviour, by either the staff or parents, was noticed.

3.8.3. My relationship with the unit

I am known by most staff at the T.L.C because of my previous involvement with the unit. During the early phases of this research I was aware of the influence that such a relationship could have on the reporting of the data. The staff of the T.L.C were my teachers and mentors, and I was concerned about being biased and too eager in my defence of the unit. However, these issues were discussed in supervision and the results were reported with an attention to the exact wording of both parents and staff.

3.9. The Researcher's Own Subjectivity and Interaction with the Research Process

It is important to consider how, as a researcher, one's own identity and experiences influence the perception and interpretation of data. I tracked two families whose backgrounds and contexts were not entirely unfamiliar to me. Nonetheless such familiarity is layered by issues of race, gender, class and ultimately power. Thus as a middle-class white female I was raised with a particular gendered perception of what makes a 'good mother'. For example, I was predisposed to view such behaviour as attending visiting hours as crucial to showing a child that they are loved and special. In the cases I followed all the parents had the means available to attend visiting hours and provide extra food and sweets for their child. Parents attending visiting hours and having regular contact with the ward is also seen by the staff as a necessity and a way in which the parents show their engagement with the unit and treatment of the child. However, if parents

did not have the financial means to attend visiting hours perhaps their absence would be interpreted as an indication of their lack of commitment and inability as a parent. Issues such as these identify how one's own upbringing and assumptions can influence perceptions of the parents within the child psychiatric in-patient environment.

It could also be argued that not having children of my own has left my own phantasies of mothering unchallenged by the realities of parenthood. This might influence my ability to truly empathise with parents, especially with parents of psychiatrically ill children. However, my experience at the T.L.C of constant and consistent contact with very ill children, as well as my training in clinical psychology, has assisted in my ability to understand the multiple facets of child behaviour. However, I retain a belief based on my own life experience and on theoretical knowledge, that parents remain responsible for their children and that they can and do maintain problem behaviours. My own training as a psychologist also at times influenced how I felt about parents when they displayed little insight into the detrimental consequences of their behaviour. For example, a parent did not understand why the T.L.C was against their child sleeping in the parent's bed. Although I felt frustration, I also understood that the staff at the T.L.C must experience a similar reaction to my own. On further reflection I also began to understand that the stress of daily life with a psychiatrically ill child could be so intense, that allowing your child to sleep in the bed may in fact be the only time of peace for the family. It is this kind of reflection that allows for a continued ability to empathise with parents who struggle with difficult children.

3.10. Conclusion

The complexities of conducting research within a clinical context are highlighted in the above section. It is argued that the qualitative approach is best suited to the aims of the study as it

provides rich data that can contribute to the understanding of child in-patient psychiatric care. The data obtained is reported in the results section and is characterised by direct quotations from both staff and parents.

CHAPTER FOUR

4. RESULTS

4.1. Introduction

This section presents the results from the interviews and case presentations. The first section outlines the two cases. Demographic details are provided as they are considered to be both pertinent to the parental experience of admitting a child to the T.L.C and are also thought to inform therapeutic alliance. The second section explores the cases separately in order to gain both the parent's and unit's perspectives of admitting a child for in-patient treatment at the T.L.C.

4.2. Case Study One: Relevant Background Details

The [4]Ismail family are devout Muslims and admitted their 14 year old daughter, Fatima, for selective mutism. Fatima was two years older than the cut-off limit for the T.L.C and is the younger of two children. Her parents are still married and own a grocery store close to where they live. The father suffers from Bi-Polar Affective Disorder and is on treatment for his condition. Due to his illness, he played a background role in Fatima's treatment and had little contact with the ward. The mother described herself as having been a quiet teenager, who would also not talk spontaneously during her adolescence. The mother suffers from epilepsy and is on medication to control her seizures. The family live about a 10-minute car drive away from the unit and have the use of their own car. Fatima was admitted for one term to the T.L.C. Staff at the T.L.C and her referring doctor thought that a short stay, with an intensive behaviour modification programme, could assist her in talking more freely.

[4] All names used are pseudonyms

At the time of her admission Fatima would speak to her immediate family and her young cousins. She would not, however, speak spontaneously, and would only respond to direct questions. Fatima was also very particular about her eating habits. She has her own set of crockery at home and would not eat at other people's houses or in restaurants. Fatima would also not eat in front of others at her school. She did well academically, but her teachers were concerned because she would not answer them in class or partake in any oral assignments.

Fatima was described by her mother as a vibrant and chatty child up until the age of four and a half, when she was hospitalised for a tonsillectomy. The mother reported that after this surgery Fatima was ridiculed by her older sister for talking strangely, and according to the family, this is the cause of her selective mutism. However, the mother reported other stresses that occurred during this time that could also account for some of Fatima's symptoms. Namely, the father had a "mental breakdown" that resulted in the family business failing and this also caused a great deal of conflict with the extended family.

Since the age of 5 Fatima has been seen by a few doctors, but the family would seldom follow through with the suggested treatment. When Fatima was younger, a private psychologist had told the family that she was merely immature and that, with time, she would interact more freely. As a result of her selective mutism she was kept back in her final year of kindergarten and only started school at age 8. Her spontaneous speech did not improve and she continued to engage with only a few family members. The mother said that the family chose to "not make a big deal" about this and believed that when her child was ready, she would interact more freely. At the time of the interview the family described Fatima as very chatty and that she would provoke fights with her sister. She was also described as being bossy at times, even telling her father what to do. However, at school Fatima remained extremely quiet and withdrawn. Although she did very well

academically, she was unable to participate in group discussion or oral assignments. Her teachers were very concerned and advised that the mother take Fatima for further treatment. She was seen at the Child and Family Unit of Red Cross Children's Hospital by a psychiatric registrar early in 2002. Apparently she had been on the waiting list for sometime before obtaining an appointment. Her case was then taken over by another registrar in 2003. The registrar suggested an in-patient stay for Fatima because she was already 14 years of age and her mutism was affecting her school performance and social interactions. There was discussion with the registrar and the staff at the T.L.C, as Fatima was two years older than the usual cut off limit, however, it was felt that the child was suitable for the unit as she was developmentally young for her age and the plan of treatment was to be for a short intensive admission, to enable her to return to school as soon as possible.

4.3. Case Study Two: Relevant Background Details

The second family is Jewish and their eleven year old son, Josh Kaplan, was admitted to the T.L.C. He was admitted for tyrannical behaviour at home and at school. He was extremely disruptive at school, and had threatened to burn the school down. He was verbally abusive to his mother and younger sister in public as well as at home. In addition to his aggressive behaviour, Josh also displayed anxiety and separation issues.

The parents divorced when Josh was six years old. They have an amicable relationship and have both been involved in parenting their two children. The mother retained custody of the children, but they spend Wednesday evenings with their father as well as alternate weekends. During the first half of 2004, the family had experienced many changes; the mother remarried and the

father's long-term girlfriend and her three children moved into the father's home. The father is an accountant and the mother is currently a housewife.

The mother reported that Josh was a difficult baby, who never slept through the night. He was colicky for six months and the mother reported that it was emotionally very draining for her and that it affected her own health. He was also developmentally delayed; walking and talking at only twenty-two months. In addition, he continued to soil his trousers up until grade one. His mother reports that bowel control was something he had never learnt properly, rather than a developmental task he had acquired and then had lost. He learned how to eat with a knife and fork only at aged eleven. He is also tactile defensive; refusing to wear clothes with tags he can feel and also insists on both his clothes and shoes being two sizes too big for him. He is described by both parents as being emotionally immature, constantly busy and has difficulty sitting still.

The Kaplan family has an extensive history of seeking professional advice. In grade one Josh was seen by an occupational therapist for tonal difficulties, but he became abusive to the therapists who then refused to work with him. In grade three Josh became increasingly agitated, he would talk about death often, he would scream at his mother in shopping centres calling her a "fucking kaffir". He was seen by several psychologists and a paediatrician who diagnosed him with Attention Deficit Hyperactivity Disorder (ADHD). One psychologist even suggested to the mother that he might develop Tourettes Syndrome in a few years. During grade three he was placed on Ritalin. Mother reported that his handwriting and schoolwork improved on the Ritalin but that he was impossible in the afternoons after school; he would chase both his mother and sister around the house with a kitchen knife. In addition, his mother also reports that he was suicidal, threatening to jump out of windows. As a result of these difficulties, the doctor who was seeing him at the time increased the dose of Ritalin, but that seemed to lead to even more

agitation and sleeping difficulties. In grade four the family took Josh to a woman who herself has three psychiatrically ill children and has developed alternative methods for treating and managing behaviourally disturbed children. She suggested a change in diet and behavioural modification therapy. Josh's mother removed all fructose, lactose and processed food from his diet and an individual therapist came after school to help Josh with his homework and to work on a behavioural modification programme. The mother reports that it worked very well for the first six months, but felt that as he became comfortable with the therapist his attitude changed; on one occasion he took a knife from the kitchen and chased the therapist around the house. Josh was then taken to see a psychiatrist who tried a range of different medications including Tofronol and Luvox. He had adverse side effects to the medications; with some he was not able to urinate and with others he became so sexually disinhibited that he would masturbate in front of his sister and rub himself up against his mother.

His disruptive behaviour at school and home escalated in the last year and he was refusing to go to school. In the last quarter of 2003 he was absent for at least half of the term. On days that he did go to school his mother would have to drive him to his father's house, which is close to the school, and then call the psychologist and principal from the school who would come up to the house and physically take him to school. His mother reported that she was unable to go to the toilet on her own, he would stand outside the door and knock asking her when she would be finished. He was sleeping in her bed at night and in his father's bed when he was staying with him. He was also waking up to 11 times a night to go to the toilet. The psychiatrist and the school team eventually made the referral to the T.L.C at the end of 2003.

During the two terms that the second case was followed, the child remained an in-patient at the T.L.C. His special nurse also changed as his first special nurse resigned from the T.L.C. Due to

the previously mentioned changes in the family's living circumstances the psychologist started seeing the mother and new stepfather together. On alternate weeks the psychologist would see the father and his live-in girlfriend.

It is clear that the symptomology and family constellations in the two cases are very different and it is therefore likely that the parents would have different experiences of the T.L.C. The Kaplan family have a child who presented with severe behavioural difficulties which are extremely distressing to the family and the school. In contrast, Fatima's difficulties are particular to her verbal interactions in public settings and the family experienced very little subjective distress. The following section describes the parent's and unit's experience of having Fatima and Josh respectively in the T.L.C unit. Each case is detailed individually to allow for two separate accounts of parental and staff experiences.

4.4. Case Study One

4.4.1. The referral process

The registrar at the Child and Family Unit seemed to play a vital role in the family's agreement to admit Fatima to the T.L.C. The mother felt that the registrar was fairly forceful in her suggestion of admission to the T.L.C. She described the registrar's recommendation in the following manner: "She was so abrupt, she said she must go in otherwise they can't do anything for her. I was a bit upset but I guess that's the doctor's way. I mean I know she was right, it was the right thing but I was very upset." The staff recognised, that the registrar is, "quite a character and tells patients directly what she thinks and what should happen. I can imagine that she said something like, 'If you don't do this, she won't have a future and it will be your fault'. But obviously in a

nicer way." However, the registrar's forthright approach was seen by the staff at the T.L.C as a positive influence on the family's decision to admit Fatima.

4.4.2. Living with a psychiatrically ill child

The staff reported that they felt the mother minimised the extent to which the child's problems impacted on her life. The psychologist reported that, "It is fairly common with families of selective mutes that they do not have a full understanding of the complexities of the problem. They explain the child as a normal, natural child. They don't pick up on how the outside world see the child, they are not party to that experience." Although the mother may have minimised the extent of her child's problems in her conversations with the staff, she did however report to me an astute awareness and embarrassment about her child's behaviour in public. She said that, "The only time she is strange is when we are around others, she acts like she is not normal. She won't answer them or even shake hands. And I can tell people think she isn't normal and, you know, it's embarrassing for me."

The embarrassment is further illustrated by the difficulties the mother had in telling others about the upcoming admission to the T.L.C. She had, in fact, only told a few people about the admission to the T.L.C. She felt that they would think that her child is not normal. She explained that, "People think that it's only children with problems who go there. Other people think it's a special school."

Interestingly, towards the end of both interviews, the mother reiterated that compared to others, her problems with Fatima are small. She stated that her family is, "really lucky compared to other families and she is such a lovely child." It seems that parents cope with their own child's

distressing behaviour by thinking about how much worse it could be and by comparing their own child to others with more severe disturbances. This was further evident in Fatima's mother's experience of the parent group. She found the group useful, but also felt that the other parents had far greater challenges than she does. She explained that Fatima is, "an angel compared to those other children, my child doesn't back chat like the others do, she's different."

4.4.3. The need to find explanations for the child's illness

Throughout the interviews it became apparent that the parents were attempting to explain to themselves and others why their children have these difficulties. As the primary caregivers the starting point was often themselves. This mother was explicit in this: "You know you blame yourself, did you do something to her. I was scared I had done something. She inherited things from us, but in a more severe way."

In addition, the mother reported feeling frustrated, as she believed that people would have difficulty in believing that her child is normal at home. She said she feels like, "the staff won't believe me when I tell them how relaxed she is at home. She even fights with her sister, really loudly. She screams and carries on". Interestingly, at the case conference the staff were indeed sceptical about the apparent normality of the sibling rivalry. The psychologist questioned, "If other people overheard this so-called fighting, would they also think it's as intense as mom reports?"

4.4.4. Anxieties evoked by the upcoming admission

The thought of admission proved to be a difficult issue for the Ismail family to accept. The mother described the time leading up to admission as very stressful. She said, "I didn't want to send her in the beginning, I just didn't want to think about it. I delayed thinking I must send her, I must send her, until I had to send her." Fatima had never slept out with anyone other than the extended family before, and reacted badly when she was told of her upcoming admission. Her mother described how Fatima, "just cried and cried and locked herself in her room."

The psychologist also reported that Fatima's grandmother had called him at the unit a few weeks before admission because, "She was worried because she had heard that there were boys here and asked if I felt that the admission was really necessary." The staff understood that it was a significant step for the family to have Fatima placed in psychiatric care away from her family, as she had been so protected and had only socialised with her extended family. The family's response was not one of aggression but rather one of anxious submission. It is noteworthy that the psychologist had a particular understanding of the family's response to the authority of the doctors and staff at the T.L.C. The psychologist reported that, "I don't think they as a family really think it is necessary, and are going along with it all because the doctors have told them that is what they have to do."

In keeping with protocol prior to admission, the staff at the T.L.C showed the family the unit, introduced them to staff members and explained how the unit functions. Not surprisingly, the mother reports that the tour was not something that she remembers very clearly: "I remember that they showed us round the unit and told us how everything works but I was a little deurmekaar (confused) on that day and can't remember any details. It's blurry."

The Ismail family found the facilities at the T.L.C adequate. The mother reported that, "the building doesn't look nice from the outside, but it's nice and clean inside. Very tidy". She also felt that the T.L.C was made more inviting by the nurses always being friendly and smiling.

4.4.5. The aims of admission

The mother understood that the aim of admission was to ensure that Fatima had a future with more possibilities. The family hoped that the admission would enable Fatima to, "talk more freely, and not wait for people to ask her a question. I mean what kind of work will she do if she can't talk to people?" The nature of the problem made it very clear for both the family and the unit as to what the primary aim of this admission would be. This was an unusual situation for the T.L.C as commented on by the psychologist, "We are not doing this as a classic TLC admission, this is an adapted admission. She is out of our age range and what we are doing here is not the norm. We are not trying to have a bonding relationship and getting to know the family dynamics. It has an intense behaviour modification angle which we will do for a term and see how far we get."

During the initial interview with the staff, it is noteworthy that even in this case where the aims and goals of treatment are clear, the 'special nurse' was not really aware of the plan of treatment for Fatima. As the psychologist spoke of the 'idea/vision' for the child, the nurse responded "I have felt like this child is a bit here and there, and today I heard the vision for the first time". This hints at the hierarchical nature of the unit and the separateness that exists between the clinicians (psychologist, psychiatrist and social worker) and the staff (nurses, teacher), which has the potential to inform the implementation and efficacy of the management plan. During the case

conference (which occurred after the initial interviews) it was apparent that very clear treatment plans were outlined and the strategies were fully discussed in order to ensure that all the members of the multi-disciplinary team were working together on the same issues.

There were other behavioural difficulties which the unit had to manage. Fatima refused to eat the T.L.C food and would only use her own crockery. This was a concern for the mother as initially she was uncertain as to what the unit's policy is with regards to food. Due to the mother's anxiety and subservient nature she did not ask about the policy. The mother explained, "I didn't give her anything to eat cause I didn't know I was allowed to. But after the first visiting day they told me I could pack her some food, so I did that. I felt better after that."

The staff acknowledged that it is not normal practice to allow a child to eat only food prepared outside of the TLC. However, due to the food issue falling outside of the primary aim of admission, the staff went someway in accommodating and making sense of this issue. In the case conference a nurse said, "Let's just get her talking, as long as she isn't starving herself." The special nurse introduced Fatima's culture as another reason why she should not have to eat the food, "some of the food they get really isn't very nice and she isn't used to eating those kinds of foods anyway." The fact that the food did not become a target behaviour during admission was attributed to the admission being of short duration with a one-dimensional focus.

4.4.6. Concerns relating to admission

The fact that Fatima was already an adolescent girl raised particular issues. The mother reported that, "She has her period already. I was worried who she would meet there. It would have been easier if she was eight years old." The staff reported similar concerns. However, they argued that,

although Fatima was 14 years of age, she was developmentally immature. This enabled her to relate better to the children at the TLC, but her removal from school caused a separation from her appropriate peer group. Her age informed the decision for a short term admission, and the psychologist explained that, "She needs to get back to school as soon as possible. We would have approached this very differently if she came to us five or six years ago. It's now way too late."

In addition, her schoolwork was another major concern. The staff reported that the mother did not complain about the schoolwork, but rather attributed her own concerns to Fatima by saying such things as, "Fatima is worried about missing so much school." The psychologist felt that the mother had difficulty expressing her own concerns so instead assigned the schoolwork issue to her daughter. This may demonstrate how the mother's submissive attitude in relation to the staff caused her to project her own anxieties onto her daughter. However, the mother reported openly to me during the interviews that she and not only her daughter were concerned about the quality of schoolwork available at the T.L.C. She stated, "Academically she is good, but things are too easy for her at the T.L.C school. She is missing out on important work, mainly group tasks and projects". Although the staffs were aware of the concerns about schoolwork they felt that, prior to admission, Fatima was probably not engaged in group tasks at school and thus believed the term at the T.L.C would be best spent on improving her ability to communicate.

4.4.7. Effects of admission on the family

The removal of a child from the family home has many consequences for a family. In the interview the mother expressed how difficult it was for her not to have her daughter with her at home. In fact, the mother seemed quite depressed as she said, "I just wanted to sleep in the afternoons. I didn't feel there was any point in watching the TV programs we used to watch

together, without her. I don't know how to describe it; it was really tough in the beginning. I missed her, the house just wasn't the same."

The staff recognised that, for this family, the hardest part of having their child at the T.L.C, would be the separation itself. The psychologist stated that he imagined that, "the hardest part for this family is the admission itself and having to hand their daughter over to strangers and a strange place." Furthermore, the mother also reported that initially she had difficulty thinking of her child as being at the T.L.C, but that the explanations given by the nurses helped her to make sense of things. She reframed the admission in her mind and found it easier to think of it as sending her child to a boarding school. She reported that, "When the doctors explained why she had to be there it became easier, it was explained so nicely by the nurses especially that I started to think of it as her just going to a boarding school".

In addition to the staff explaining the reasons for admission, the constant flow of positive feedback from the staff to the mother also made the admission more bearable. The mother explains that, "It was mainly positive feedback about her and every time I heard such good things it made me think she is closer to coming home and there is hope; that this is working." By staff addressing the mother's anxiety about admission, and providing constant positive feedback the mother began to trust in the fact that she was doing the right thing. The psychologist stated that, "over time this trust enabled her to believe that nothing dreadful would happen to her child at the T.L.C."

4.4.8. Effects of admission on the unit

Due to the clear plan and circumscribed nature of the case, the staff found Fatima's admission manageable. In addition, the child was quiet and obedient in class. In contrast to the other children they had at the T.L.C, she was not a management problem. The mother was also not demanding of the staff or their time. She was submissive and respectful of the staff. The most taxing part of the admission for the staff was that they had to maintain constant pressure on Fatima in order to ensure the behaviour modification programme was administered effectively. However, Fatima was more often than not compliant with the demands placed on her by the staff.

The clear behavioural programme and short duration of admission seemed to have united the staff of the T.L.C. The special nurse reported that she was proud of the staff as they had all worked together to help Fatima. She explained, "We were all working together, like a big family to get her talking, even the other children were helping her. It was a team effort." The psychologist spoke of how all staff were involved in the programme which often required staff members to do things outside of their job description; for example, the teacher would have to help with relaxation exercises. Fatima's presence brought the staff of the T.L.C together, perhaps supported by the fact that staff were able to see tangible results and the intensity of work and pressure was required for only one term.

4.4.9. Parental access to the T.L.C.

No difficulties were reported by Fatima's mother, in connection with the visiting hours of the T.L.C. Fatima did not want her father to come and visit her during visiting hours for fear he might embarrass her. Her mother would go every week and would sit with Fatima for an hour or

so. The mother reports that the visiting hours were sufficient and she felt they had enough privacy when they were together.

In addition, the mother would call her daughter every night, but Fatima refused to talk to her on the phone, and so Fatima's mother would, instead, ask the nurses how everything was going. The staff felt that this was perhaps very difficult for the mother to cope with. The 'special nurse' said, "She would phone every night but her child would not speak to her." However, her mother explained that she was used to her child not wanting to talk on the phone and she knew it was important for her to know she was calling whether she spoke to her or not.

4.4.10. The relationship between staff members and the parent

This family's anxious but compliant response to the unit and the unit's clear management plan fostered a good relationship between the mother and the staff. Overall, the staff described the relationship with the mother as being, "friendly and hopeful, she had a submissive attitude towards professionals; they know and we must just trust them." The mother reported a close and easy relationship with the nursing staff especially with the 'special nurse' whom she described as, "so helpful and friendly and she tells me what I have to do". However, in contrast, the 'special nurse' did not feel very close to the mother. The special nurse was also on night duty during the first few weeks of the child's admission and so had very little contact with the mother. The 'special nurse' reported the relationship to be quite disjointed: "We would spend just five to ten minutes every here and there but it felt like she was waiting for me to tell her what to do". The relationship improved over time with more frequent yet short interactions between the mother and 'special nurse'; thus indicating that it need not be taxing for the unit to establish a working

relationship when there is a clear difficulty and there is opportunity for brief, mainly positive, feedback.

The mother spoke of her relationship with the psychologist with more apprehension and anxiety, perhaps due to the fact that the mother saw the psychologist as holding a more senior position. She said that on Mondays when she would see him she would not have much to tell him. She felt this was because often on weekends the child would sleep out at the grandmother or cousins and the mother would then only see her on Sunday night. The psychologist reported that the relationship felt, "limited and that every Monday was a report and description of the weekend that was vague with little or no detail or texture." The 'special nurse' during the interview reminded the psychologist that often the mother did not see the child during the weekend and was only reporting what the family had told her. However, the psychologist felt more was involved with regards to how the mother interacted with him. He understood she was shy and perhaps did not have much contact with her child over the weekend, but was also aware of the influence his gender, religion, race and position may have on the relationship. He mentioned to me that I may be able to obtain more information from her because of my gender.

The level of the staff's investment in the case was mediated by the duration of stay as well as their perceptions of the parent's capacity for change. The psychologist reported that the unit was intentionally keeping out of family dynamics and he felt that, because the child was only being admitted for such a short time, it was appropriate to not "push" the relationship. He went on to say that he felt that the mother, "does not have the capacity to get close to or connect to people." It is noteworthy that the mother opened up significantly to me during the interviews and I felt welcomed into her world and feelings, perhaps influenced by the fact that she was in her own

home, but nonetheless indicating the effect that issues such as gender and authority can exert on the quality of a relationship.

The mother's trust in the unit and relationship with the staff did not seem to be affected by the fact that she was unclear about the job descriptions of the different professions at the T.L.C. Her need to trust in the authority and skills of the professionals caused her not to be concerned with the functioning of the unit. She said that, "I know they told me all about it but I don't know really who does what or how it works, but then it doesn't really matter because they all take care of Fatima." The staff agreed that they felt the mother wasn't quite sure about how the unit works and that it was made more confusing by the psychologist performing the social work function in the unit as well. The psychologist stated that, "I don't think she knows what I do, because I said she must go and see the social worker but then she came to see me, but she also has the attitude of: they are the professionals, they know what do to and we much just trust them".

The exclusion of a parent in the treatment process is usually a major concern for staff at the T.L.C. However, the staff agreed with the exclusion of the father from the T.L.C and attributed this exclusion to his diagnosis of Bi-Polar Affective Disorder. The staff felt that he had a fairly blunted affect and was perhaps over medicated. They also felt that the father was not given a place in the family and that, in some ways, he is another child to the mother. Nonetheless, the psychologist did not push the father to be included in the process and no challenge was made to this in the case conference. The T.L.C's exclusion of the father re-enacted the father's place in his own family; he is an outsider with no voice or opinion. However, Fatima's discrete difficulty and short admission made it unnecessary for the staff to delve into the broader, arguably more intractable, familial dynamics.

4.4.11. Discharge

The separation difficulty between mother and daughter motivated Fatima to do everything she could so that she could return home as soon as possible. However, the sustainability of the progress she made was an issue for her mother. The mother reported that, "She talks loudly and reads 'cause she wants to get out of there, but what if she comes out and goes back to not talking."

Ultimately, the mother reported that she would recommend the TLC to other parents. She felt overall that they were professional, and although she was concerned about sustainability, she was certain that the TLC had definitely helped her child.

The child was discharged after one term. She had a very supportive school that continued with the behaviour modification programme. She did not have to be kept back a year at school and is currently in grade eight.

4.5. Case Study Two

4.5.1. The referral process

Josh Kaplan was referred after a prolonged and difficult time at school and at home. His mother found it extremely hard to get him to go to school in the mornings and all the professionals involved in the case felt it was necessary to refer Josh to the T.L.C. In addition the mother felt that she was at the end of her tether and that admission seemed like the only option at the time. She explained that, "Out of desperation I thought I would give it a try. I had reached the end of the road. If something didn't happen I would have had a breakdown." However, the mother

remained ambivalent about the referral to the T.L.C. She was concerned about the removal of her child from her care, These feelings escalated just prior to admission and are reported on later in this chapter. The father also felt that he did not know where else to turn with regard to his son and felt unequipped to handle Josh's difficult behaviour. He also, much like the previous case, demonstrated a trust in the professionals that helped him in accepting the referral. The father reported that, "It got to the point where you want to do what's best for your child and you have to rely on the experts. I can't treat him myself, I don't have the time or the capacity, I just want him to be normal."

4.5.2. Living with a psychiatrically ill child

The mother described what it has been like for her to live with her son, and how his behaviour directly affects her emotional well-being. She explained that, "its like living on the edge all the time. There have been times when I have just wanted a bus to drive over me, or I feel like I am going to kill him so I lock myself in my bedroom." Josh's mother has been treated by a psychiatrist and placed on anti-depressant medication. She also explained that the family become accustomed to the abnormal behaviour. She said that, "you don't know any different and after a while it becomes the norm, the abnormal is normal for us."

In addition, the mother also spoke of the social isolation that may result from living with a psychiatrically ill child. She explained that, "While I have been going though this with my son I have always felt very, very alone. I didn't ever socialise cause I had a difficult child and I didn't have friends and neither did he. People just don't understand." She also explained how she felt people judged her. She said, "they think that I can't handle my own child and that I'm a good for nothing mother."

Interestingly, just as with the Ismail family, towards the end of the interviews the parents would mention the good in their child and compare Josh to other children and families who are comparatively worse off. It seems this is a coping strategy these parents employ to remain hopeful about their child. The mother said that, "he really is the most beautiful child, he looks like an angel. Given half the chance he would be such a sociable child." His father also said, "I think about other families with children who are retarded and things like that and, really, we don't have that much to complain about. You know he is very, very bright and you should see him with his music. He wants to be a DJ."

4.5.3. The need to find explanations for the child's illness

There is a need for parents to make sense of their child's difficulties and just as with the Ismail family, Josh's father looked to himself first. During the initial interview the father spent a great deal of time hypothesizing about the causes of Josh's behaviour. He said that, "maybe I was too soft on him but one doesn't know, maybe it was the divorce? I've often questioned myself where he gets these things from? I think there is one thing he takes from me; I get agitated when things don't get done quickly and I am moody also." In contrast, the mother saw Josh's difficulties as originating from inside of him. She felt he had come into the world with difficulties such as colic and delayed developmental milestones, and felt the diagnosis of ADHD encapsulated his difficulties. The importance of understanding the parent's explanations for their child's illness is explored in detail in the discussion chapter of this thesis.

4.5.4. Anxieties evoked by the upcoming admission

The mother reported extreme emotional difficulties leading up to admission. She feared the upcoming separation from her son and was worried about Josh's safety. She reported that, " I was freaking out, freaking out big time. I couldn't sleep the first two weeks before T.L.C. I was fearing a mother handing over her child to 20 strangers. What are they going to do with my son? What if he gets attacked in the middle of the night? What happens if there are paedophiles there? It was a heart wrenching experience to think about letting go of my son."

The mother also spoke about how the upcoming admission triggered her feelings of being an inadequate mother. These feelings of inadequacy were amplified by the mother's sense of being judged by her own community. She reported how people she knew would ask her how she could do this to her child. She felt this was more intense for her as she is from a Jewish family where it is not culturally acceptable to allow your child to be away from the family for an extended period. The mother defended against these feelings by stating that, "Internally I knew that it was the best thing for me and my child." The father also reported difficulties in telling others about the admission. He explained that "I just tell them he is there to sort out the ADHD as he needs special attention, but I don't tell a lot of people."

The staff recognised how difficult the mother would find Josh's admission. The psychologist explained that, "I don't think having him at the T.L.C will be easy for this mother, she may see herself as a bad mother who has put her child away, but on the other hand she has found a space where people will listen. The psychologist also stated that he understood how difficult things are at home for the family and felt that, "the mom is really having a hard time with this boy, she is scared about admission, but motivated."

The anxiety evoked by the upcoming admission seems to be so overwhelming that it impedes the parent's ability to absorb information. As with Fatima's mother who also reported that she was so confused during the tour of the T.L.C that she did not remember much, Josh's mother explained that, "I know they gave us a tour and explained everything but I was so confused and overwhelmed I didn't absorb anything." She also suggested an evening with all new parents and staff before admission to explain the running of the unit again to them. She said that, "it would have been nice to connect with similar parents early on, before admission, to hear about their expectations and to hear how the T.L.C was going to care for our children."

4.5.5. The aims of admission

Unlike the previous family, the aims of Josh's treatment were less clear on admission. His problem behaviours were not as circumscribed as Fatima's and this could account for the fact that the Kaplan family had broad expectations, without operationalising specific goals. The father expressed a wish for his son to just be normal. He said that, " I just want him to be able to cope better, to be more independent and they do those things there at the T.L.C". The mother reported that, "Personally I want him to be 100% in control of managing his behaviour. Maybe I'm hoping for some kind of magic that would enable him to become mature emotionally."

On admission, the unit also had aims that were not as clear or tangible as those for Fatima. During the initial interview the psychologist reported that the aims of admission were, "to assess the level of anxiety in the child and to treat it, as well as to explore the secondary gains the child's behaviour generates". In addition the duration of Josh's admission was not set; it was thought that he would have to remain at T.L.C for the duration of 2004, but that this was subject

to change, depending on his progress. It seems that Josh's case was more standard for the T.L.C, as often there is a period of assessment where the unit gains a deeper understanding of the case before utilising a specific diagnosis or implementing clear management goals.

4.5.6. Concerns relating to admission

As with the previous family, the mother reported concerns about the sustainability of any progress made at the T.L.C. She saw the T.L.C as an artificial environment that is not like the real world. In the first interview she said that, "It's a brilliant situation while the child is in it but when he comes out into the real world I wonder how he is going to be?"

The mother's concern was around sustainability after discharge, but the staff were concerned about the transference and sustainability of the behavioural modification programme from the T.L.C to the home environment. During the first case conference, the psychologist doubted the ability of the parents to implement and maintain the behavioural modification programme at home, and noted that this family had difficulties with regards to limit setting and boundaries.

In addition to the sustainability issues, both parents expressed concerns about the education their child was receiving at the T.L.C. The mother commented that, "He's getting government education but he comes from a private school. I could be up for correction, but I think he is way behind and if we want him to be mainstreamed on discharge I am worried as that means more anxiety and extra pressure for my child." The father expressed similar concerns and said that, " I don't understand how the school works there, with different grades in the same classroom and I am worried his school work will go backwards."

Josh's parents were also concerned about the opportunities for Josh to make friends and practice the social skills he had been learning at the T.L.C. The Kaplan family are used to a school environment that provides an array of extra-mural and social activities. His mother reported that, "I understand that they don't want the kids to socialise with other T.L.C kids on the weekends and stuff, but what do you do when your child says 'mommy, please find me a friend'?" The father also reported a lack of extra-mural activities including socialising with other children and sport. The parents felt it would be very useful to have regular sporting activities for the children to engage in after school at the T.L.C.

Both parents spoke about the condition of the unit as being run down. The mother reported that the T.L.C was dingy and impersonal and would benefit from a more child friendly atmosphere. She explained that, "a more personal environment would let the child feel like it's going to be okay."

4.5.7. Effects of admission on the family

The first day of admission was very stressful for the mother, and this was exacerbated by her perception of the facilities at the T.L.C. She said that, "I walked around that place and it's so dark and smells like someone has puked and weed in the bedrooms. I sobbed in my car all the way home. I felt terrible, like I was sentencing my child to boot camp with hard labour." The special nurse was aware of this, as she reported during the initial interview how difficult it had been for the mother on the first day. The special nurse said that, "She just broke down and I was the closest one to her so I went up and held her for a while, she really was very distraught". It seems that this kind of interaction was helpful as the mother reports that, 'the staff really were very helpful on that first day and put a lot of my fears to rest'.

Josh's admission to the T.L.C not only impacts on his parents but on his sibling as well. The parents reported that their daughter is enjoying being the only child at home. The mother said, "His sister is delighted, if people ask her if she has a brother she says she is the only child. It's really a relief for her not to have him around."

It was suspected by both the staff and Josh's parents that the tyrannical behaviour that Josh exhibits at home and in public with his family, would become evident at the T.L.C. The staff were expecting a great deal of difficult behaviour that they would have to manage. However, since admission in January 2004, Josh has not displayed his disrespectful and tantrum like behaviour at the T.L.C, although his outbursts continue to be common at both his mother and father's home during weekends. The mother grew concerned about how the staff would start to perceive her and whether they would be able to believe and understand her child's problem behaviours fully. She said that, "They think my child is perfectly normal. I wish I could just pinch him so that they could see his tantrum so that they won't think I am off my head. I said to him the sooner you show them the sooner you will get better. They can teach you how to manage yourself because mommy is not qualified to do that."

The mother's anxieties about the staff believing her and understanding the extent of Josh's behaviour escalated during the mid year break. The parents reported a very difficult time. The mother said, "If only I had a video camera, because they can not believe that he can get up to this stuff. They may believe it but they have never seen it. They really can't believe my child can be a lunatic. I wish I had taped it. Boy oh boy, that would have been a learning curve for any social worker or psychologist in this whole T.L.C unit." However, the psychologist at the T.L.C seemed to understand the mother's dilemma and did not doubt the child's behaviour. The psychologist

reported that, "Mom doesn't think we believe her about what her child can get up to, but I do. I don't think any of us doubt that what they report is real. I can see him doing it all." In contrast to the mother, Josh's father feels that the staff does understand what it is like to have a child like his. He explains that, " They get it, they know what it's like to have a child like this."

Despite the fact that Josh has not displayed his tyrannical behaviour at the T.L.C, both parents report gains that have been made since admission. During the second interview his mother reported that Josh sleeps in his own bed, does not wake up during the middle of the night, is less tactilely defensive and urinates in the toilet as opposed to all over the bathroom. In addition, his father reported that Josh makes his own bed and that there are no problems in the morning when he has to get ready to go to the T.L.C.

The expense of the admission was highlighted as an issue during the second interviews with both parents. The father is paying for Josh's admission privately as his medical aid does not fund prolonged psychiatric hospitalisation. The admission costs Josh's father approximately R900 a day. The financial aspects of the admission seemed to be of greater concern due to the fact that, although Josh has shown improvement, he has not met his parent's expectations of 'normality'. The mother reported that her ex-husband complained about the expense and hypothesized that he felt like he was paying so much money yet Josh wasn't "coming right". However, the justification of the expense for both parents is the belief that they need to try everything they can to help their son.

4.5.8. Effects of admission on the unit

Children with extreme behavioural difficulties may cause a great deal of tension in a unit. Although the tyrannical behaviour was not present in the ward, Josh's internal struggle spilt over into the ward. Both 'special nurses' and the psychologist reported that the child had the ability to split the staff in the unit. The first 'special nurse' explained that, "He splits the staff against the mother, he splits the day and night staff and he's experienced in the unit as being sly and manipulative." Josh was seen as a child who had the ability to play the staff off one another, but the unit recognised this early on in his admission and stopped him by acting as a team and pointing out his behaviour.

This difficulty of splitting can also be experienced between the staff and parents, which is exacerbated by the fact that Josh is the perfect patient at the T.L.C, yet at home his tyrannical behaviour continues. During admission the staff became frustrated with the parents and started to see them as incapable of understanding their role in the maintenance of Josh's behaviour. The psychologist reported that during his meetings with the parents, they would analyse a situation in which the child has acted out at home. Although the parents engage in the discussion the psychologist explained that the conversation reaches a certain point and then, "it's like: don't expect me to do anything about it - my child is just too powerful. They can't see how their lack of firmness contributes to his behaviour. I just want to take the dad and shake him." In an effort to push for change, the psychologist incorporated the father's girlfriend and mother's new husband in the feedback sessions. The psychologist found this to be helpful, but it confirmed for him the difficulties Josh's own parents have with limit setting and boundaries.

The split between the staff and parents is further compounded by the mother's explanation for the difference in Josh's behaviour at home and at the T.L.C. In an effort to defend against the perceived attack on her mothering, Josh's mother reports that, "they are very strict there at the T.L.C and he holds it in for the whole week. You see, he feels very safe with me so he just off loads when he comes home. I'm like his punch bag."

Unlike the first case, where the mother responded to the unit with anxious submission, Josh's mother's anxiety seemed to result in staff feeling that she is threatening and over intrusive. The staff were not comfortable with the mother's behaviour and felt that she was inappropriate in the ward. There was a sense that the mother activates anxiety by questioning things and being overfamiliar and histrionic. The mother is felt by the staff to have a powerful disabling presence and the 'special nurse' mentioned that she hoped that the psychologist would talk to the mother about her intrusiveness, so that she would not have to. This was further illustrated during the first case conference where there was discussion about placing the child on medication. However, due to mother's report on the side effects, the psychiatrist said "we need to start laying the foundation with the mom about medication. This is difficult territory with her, let's test the waters but start low and slow". Then a nurse disputed this and said "I think we should leave the meds for now. I don't think we can handle mom's questions."

4.5.9. Parental access to the T.L.C

Both parents felt that the visiting hours of the T.L.C were sufficient. However, the father reported that it was sometimes difficult for him, as he would have to leave work in order to get to the T.L.C on Wednesday afternoons. The mother also reported that she was very busy and she was fitting in visiting her son between her other responsibilities and her other child. She also said how

she often felt like her son did not want her there because he was busy with other things. In addition to visiting hours, the mother telephones the unit every evening. Josh may not come to the phone because he is busy but he insists that his mother call every night.

4.5.10. Differing discipline philosophies between the staff and the parents

The mother reported a real difficulty in understanding the strict discipline and rules of the unit. One of the rules was that on the first day of admission she was required to drop Josh off, but she felt that as his mother she should have been able to help him settle in by making his bed or laying his clothes out. The father also reported that he was quite shocked that it was such an issue that his son slept with him in the same bed. He explained, "You know I really didn't mind, it didn't bother me, but for them it was a total no no."

In addition, the mother reported feeling that the discipline at the T.L.C was at times unnecessary. She reported that, "The discipline is often for menial things that are ridiculous, but who knows? Maybe they aren't ridiculous, I don't know." There is also a disagreement in terms of smacking the child. The mother has always smacked her son when he is exceptionally rude and the unit does not allow or encourage smacking. The mother reported that, "I've been finding it very hard. It's like asking a leopard to change their spots. What do you do when your child calls you a 'fuck wit' or a 'horse fucker'? I smacked him through his mouth and for them that would be taboo."

The unit has been encouraging the mother to use other discipline techniques such as time out or sitting on him. However the mother reported that she felt that the staff don't understand how difficult it is for her to utilise such techniques on her own at home. "I've tried to do what they say

but he kicks and pushes me. I can't physically remove him from the situation. We can battle all day long and I don't work in shifts, I can't take a break or call others to help me."

The differences in opinion about discipline between the parents and the unit was highlighted in an incident between the mother and a nurse. This incident caused the mother to question her role in the treatment of her son. The mother reports the incident as follows: "The staff are generally great, but (SIGH) are they specially qualified to deal with these kinds of children or are they just nurses? I don't know. I was fetching my son and I was talking to this one nurse and my child butted in and this nurse said to him, 'I told you not to butt in, if you do that you can go and write lines or go to timeout.' I thought to myself, hang on a second, this is my child and I've now come into this situation and I thought I should have taken that role over. It wasn't her right. I was so shocked because for once I had nothing to say, I mean **don't mind me I'm just the parent**. Usually if someone has to cross me I have something to say, but I was too taken aback. I thought it was uncalled for because I didn't feel it was bad enough to warrant a reprimand it was just normal behaviour. But then on the other hand I am not a psychologist or social worker but surely there is a basic understanding of human behaviour."

This situation highlights the mother's turmoil of not knowing her role when she is in the unit. Although the staff perceive her as threatening and intrusive, in this incident she feels deskilled by the nurse and starts to question her own judgement. In addition she perceives the incident as an insult to her mothering ability and, as a defence, starts to lose trust in the staff at the T.L.C by questioning their credentials.

4.5.11. The relationship between staff members and parents

Despite the differences between the parents and staff, the mother reported that the staff are friendly and helpful. In addition she said that, "the children are always supervised and the staff are female so the children get that nurturing which is so important." The father reported that he trusted the staff, "they are very organised there and the guy in charge really seems to know what to do." As with the first case the parents were not sure about the different roles of the staff at the T.L.C or the exact functioning of the unit, however, it seemed unimportant to them, as they perceived the staff to function as a team.

Both parents reported on the 'special nurses' being available and kind. They described the psychologist as being competent and firm and that the sessions with him were very useful. However, the mother did report a bit of uncertainty as to what the sessions were supposed to be about. She said, "I'm not sure what I am supposed to do. Is it time where I get to unload, a kind of a support thing, or is it a report back on how he is doing?"

The staff experienced the father as compliant yet not truly engaged with the process. The second special nurse said, "I feel like I have to catch him, he scuffles away so quickly. They describe the father as a man who has difficulty coping with emotional material. The psychologist said, "It's like emotions are a foreign language for him." In this way they perceive the father as a man who does not have the emotional capacity to engage with the process or to understand the implications of his own behaviour on his son.

The psychologist described a positive relationship with the mother. He felt her forthright manner was a strength, and that she was a resilient woman who was honest and open. He said that he felt

he was able to tell her anything and that he could understand why she is struggling. He said, "I'm not harsh, maybe blunt, but not harsh. I don't want to say I have a soft spot for her but I can see why she is struggling and she really is trying. I don't think the rest of the staff feel that way." As stated earlier, the 'special nurse' reported that the staff do find the mother intrusive and tend to avoid her when she is in the unit. However, the mother explained her behaviour as a means to ensure her child's safety, and connectedness with the unit. She said, "the staff all seem nice but I get to know these people cause they are dealing with my son. I almost impose on their thing and ask 'so how are we doing today, what's happening?' and what and what and what cause I want to know!"

Relationships can be influenced by expectations and misinformation. Shortly after the change over in 'special nurses', the new 'special nurse' reported that, "the child wasn't happy with me so mom wasn't happy with me. But she is warming slowly and things are better." However the mom reported a very different account of the relationship. She said she had always liked the second 'special nurse' and had originally wanted her as she thought she would be good for her son. This highlights how possible feelings of inadequacy residing within staff members may influence the perception of the quality of the relationship between parents and staff.

The issue of incorrect expectations or misinformation was again highlighted during the second interview with the staff. There were reports about the family looking for schools for the child to attend after discharge. They had not spoken to the parents directly about this but the child was reporting that his parents were investigating various schools. The special nurse said: "The parents want to discharge him as there was no change during the holidays, dad definitely wants the child to move." This highlights the staff's own frustration with the child's lack of improvement as well as the assumption that the parents will blame and punish the T.L.C for not effecting adequate

change. However, the interviews with the parents revealed that they were not looking at discharging Josh. The mother said, "They said initially that he would be in for not less than six months, probably a year. But we need to look at schools for next year". The father also said "I need to convince them there at the T.L.C that he should go to boarding school next year". However, the staff had mentioned since the first case conference that the child should be bridged on discharge to boarding school, as it would be the most appropriate place for him. It is arguable that the staff's fear of mother's volatility and father's perceived incapacity for change influenced their own perceptions of what the parents are thinking. In the two instances mentioned above the staff were incorrect in their assumptions about the feelings of the parents.

In the previous case, the parent group helped the mother feel like her child had fewer issues than any other child at the T.L.C. For Fatima's mother the parent groups were a positive experience. However, Josh's parents did not find the parent groups particularly useful. The father attended the parent groups and explained that, "they ask you to go and for them it is important, so I go. I don't want to miss out on anything." The staff understood the father's attendance as a gesture of compliance. The mother however, stopped attending parent groups. She said, "They don't give us a means to an end. You go home feeling heavy and saddled with everyone else's baggage. No one discusses ways of dealing with it, like have you tried this technique or you need to do that. They should turn it around from being such a misery into something positive. Really, I refuse to go." On hypothesizing about the mother's lack of attendance at the parent group the psychologist and 'special nurse' imagined that the mother had been directly challenged by one of the facilitators in the group. The psychologist said that, "I would imagine she wouldn't like that very much and so won't go back."

4.5.12. A change in diagnosis

On admission the parents and staff felt that the child did suffer from ADHD, as well as other separation and anxiety issues. However, during the follow up interviews the mother expressed confusion about the child's diagnosis. She said that," I really don't know what to think anymore, he's now on Prozac cause they maintain he is not ADHD. They say there is nothing wrong with his attention span but I say hello, you try and have a conversation with him, he can't if he's not interested. From the books I have read there are too many symptoms that he is ADHD, but he is not Bipolar that I know." The father also maintains that the ADHD diagnosis is correct. It is important to consider that the Kaplan family have been to numerous professionals before the T.L.C and have utilized the ADHD diagnosis as a means of making sense of their child's difficulties. However, as the staff have grown in their understanding of the case, they have moved away from the diagnosis of ADHD. Instead they have diagnosed Josh with primarily a V-Code diagnosis (parent child relationship problems) with an underlying Generalised Anxiety Disorder.

4.5.13. The T.L.C's continued hope for Josh

Josh is set to remain an in-patient at the TLC till the end of 2004. The staff report that they are not totally hopeless about this case, as there is the sense that the child is gaining from the admission even if the parents are not able to change dramatically. The psychologist reported, "I am not totally hopeless because it does feel like we are only half way. This is one of those cases I don't think the parents are going to change particularly but I think the child will grow and take things away with him." In this way staff are able to motivate themselves to continue working and caring for Josh and not to become incapacitated by the perception of the parents' inability to change.

What is noteworthy is that, in the previous case, the duration of admission and circumscribed nature of the problem were the mediating factors in the investment of staff in the relationship with the mother. However, in this case despite the prolonged admission, the mediating factor in the investment in the relationship with the parents seems to be the staff perception of the parent's inability to change.

4.6. Conclusion

This chapter highlighted the process of admitting both Fatima and Josh to the T.L.C. It has explored some of the issues facing Fatima's and Josh's parents who live with a psychiatrically ill child, as well as illustrating how caring for such a child can impact on the parent's own health and mental well-being. In addition, the chapter explored the anxieties that these parents experienced both prior to and during admission. The results showed that the time prior to admission was the most stressful for these parents. The effects of the admission on both the staff and the families were mentioned. It was shown that the more circumscribed case was more manageable for the staff, and the less difficulties there were in the working relationship between the staff and parent. In contrast, the second case highlighted differences in opinion and expectations between the staff and parents as a means to illustrate the difficulties that can occur in the relationship. In the following chapter the results are discussed in light of relevant literature in an attempt to address both the parental experiences of the T.L.C as well as the factors that foster or hinder therapeutic alliance.

CHAPTER FIVE

5. DISCUSSION

5.1. Introduction

This chapter explores the results in the context of the literature reviewed earlier in the thesis. Issues are examined as a means to gain a deeper understanding of the relationship between parents and staff in a child in-patient psychiatric unit. The headings used have been informed by both the literature and the themes that emerged in the results section of the thesis.

5.2. Parents of Psychiatrically Ill Children

Parents of psychiatrically ill children face many challenges. Of significance to the mental health care profession is the understanding that parents are often traumatized by daily life with a psychiatrically ill child (Klauber, 1998). The parents interviewed showed the effects of caring for a psychiatrically ill child. Fatima's mother reported embarrassment when her child would not talk socially, despite staff feeling that she minimizes the extent of her daughter's difficulties. The shame associated with a child whose behaviour may be unpredictable or inappropriate may be very burdensome for a parent to cope with. The Kaplan family experienced more overt trauma, with both parents reporting physical and emotional stress over many years. These stresses were exacerbated by a perceived disapproving or judgemental response by the extended family and social network. As a result, both Kaplan parents became isolated and stopped engaging socially with other people.

Staff need to be aware of what research has shown (Gudmundsson & Masson, 2002); that a high percentage of parents of psychiatrically ill children have a poor quality of life and themselves suffer from a mental illness. It is noteworthy that Fatima's father has Bi-Polar Affective Disorder

and Josh's mother was treated by a psychiatrist and placed on anti-depressants. Vulnerable parents may find it even harder to cope with their children. Thus, already overburdened staff of in-patient units need to not only address the issues in the children but also ensure appropriate referrals and adequate treatment for parents (Puotiniemi, Kyngas et al., 2001).

The stigma of living with a disturbed child is further increased when the child is admitted to a psychiatric unit. Admission is an emotionally laden decision, as parents fear being judged by others and there is a sense of shame in being seen as parents who are unable to cope with their child. The difficulty of telling others was evident with both families. The Ismail family did not tell many people about Fatima's admission, however, they are a family who tend to only socialize with each other and this may account for the limited number of people told. In the Kaplan family, however, the mother reported feeling judged by her family and friends, as they questioned if the admission was appropriate. In addition, the mother reported that it felt as though the admission would in some way confirm their perceptions that she could not cope with her child. Josh's father also seemed embarrassed about the admission as he told only those people who asked, and he referred to the T.L.C as a school who caters for children with ADHD. This illustrates the methods parents may employ to cope with the shame and embarrassment that admission may elicit. The T.L.C is formulated in the minds of the parents interviewed as a "special school" or "boarding school" as a means to defend against the overwhelming thought of their child being removed from their care and placed in a psychiatric hospital.

Shame may be the tangible emotion that is evident when parents speak of their daily lives with their children or the difficulties with admission, but underlying the shame is the often unconscious anxiety that they, as parents, are to blame for their child's behaviour. Parent blame is

a theme that runs throughout this discussion and informs all aspects of the interactions between staff and parents.

A parent's belief that they are to blame for their child's condition is sometimes more conscious in certain parents than others. For example, Fatima's mother, early on in the interview, assumed responsibility by asking what she had done to cause her child's silence. In contrast, Josh's mother was looking for help for her son, but was not accepting or attributing the responsibility to herself. It is hypothesized that when parents assume responsibility they are more likely to adopt a submissive, compliant attitude towards staff. However, parents who locate the problem firmly in the child, without acknowledging their own influence on the problem, have more difficulty in engaging with staff in a cooperative manner and thus may adopt a more defiant defensive pattern. In this way it is possible to understand how the defences that parents employ to counteract underlying anxieties of blame, inform the manner in which parents interact with the unit. (This is discussed further later in the chapter in terms of the impact of diagnosis.) In addition, the unit reacts to the parents in different ways. Scharer (1999) refers to the fact that nurses expect parents to be open to learning and to understand the need for change in their own, as well as their child's behaviour. Thus, there is an assumption that parents will assume responsibility and defer to the knowledge of the unit. However, Scharer (1999) does not explore why a parent may find such a change in their own behaviour as difficult. It is arguable that Josh's mother is unable to change in the way the staff expect her to, not because she doesn't understand the need to modify her behaviour, but because such a change will require an acknowledgement of the unconscious anxiety of self- blame that she defends so hard against.

The defensive strategies employed are informed by other issues, such as previous interactions with professionals and the parent's own response to authority. Unlike Fatima's mother, Josh's

mother is not in awe of professionals or protocol. It is important to note that the Kaplan family have been involved with mental health professionals for many years and have become accustomed to psychiatric and psychological input that has not been successful with regards to the relief of Josh's symptoms. The Kaplan family have thus become psychologised and are also disillusioned with the mental health profession. In contrast, the Ismail family remain in awe of the medical model and the healing powers of the T.L.C, enabling the staff to interact with the Ismail family with far more ease. However, it is important to note that although it is far easier for a unit to relate to a parent who is not confrontational or outwardly defensive, the ease of interaction is not in itself an indicator of therapeutic alliance. A confrontational parent may be far more engaged with the unit and involved in the treatment of their child, than a quiet submissive parent who does as they are told. What is crucial for staff members to ascertain is the defensive pattern parents employ in order to respond in a manner that addresses the underlying anxiety as opposed to merely the surface behaviour.

By retaining an understanding of the core anxieties inherent in being a parent of a psychiatrically ill child, it is possible to explore the difficulties expected in the decision to admit a child to an in-patient unit.

5.3. Pre - Admission

Scharer (1999) reports that parents tend to admit their child after a pivotal event. This is true in both the case studies. Fatima was admitted after the doctor, in a very stern and forthright manner, warned the mother what the consequences would be for their child if she were not admitted. Although distressing for the family, it does seem to have shocked them into agreeing to admission. The mother reported not knowing how serious her daughter's condition was until the

referring doctor told her. It is arguable that if the doctor was not as firm with the family, that they would have not agreed to the admission. The Kaplan family had experienced the last term of the previous year as extremely distressing and felt as if they had no other alternative. In both cases the family's trust in the referring doctors and the knowledge that they could not continue as they were, initially helped them with accepting the referral. Another motivating factor seemed to be that, as parents, there is a need to do the right thing and to ensure the best possible future for their children.

5.3.1. Ambivalence evoked by admission

Both families were motivated to admit their children to the T.L.C in the hope that admission may result in their child being 'normal'. Despite this and the trust they had in the referring doctors, both mothers reported extreme distress prior to the admission of their child. They were worried about the safety of their children and for the Ismail family, Fatima had never slept outside of the family before. The ambivalent feelings prior to admission are characterized by, on the one hand, feeling guilty for sending their child away from home and, on the other hand, relief that they would be receiving the help they require. In the Kaplan family, the mother seemed to continue to struggle as she constantly had to tell herself that the admission was the best thing for her child, but also felt guilty about sending him away from home. There was also, however, some relief on admission, especially for Josh's sister, as life was far more peaceful at home. In addition to conscious anxieties there was also the unconscious anxiety that the admission might confirm that the child would be better outside the care of their immediate family. Again, it is this unconscious phantasy, and resulting defensive mechanisms that informs the parents interactions with the units.

Child psychiatric units are often seen as a last resort and staff are accustomed to dealing with cases that do not show improvement (Jacobs and Green, 1998). Nonetheless, this can result in staff feeling demotivated, and may increase the staff's own anxiety and sense of inadequacy. In order to ensure that the T.L.C treats cases that do show the possibility of improvement, the unit has strict admission criteria. As a policy, older conduct disordered children are not admitted, and this decision is supported by global literature (Kazdin, 1997; Brunk, 2000) that confirms that psychiatric admission for older conduct disordered children is not an effective method of treatment. However, when the children admitted have other psychiatric conditions, the unit has little research on the efficiency of in-patient treatment to support their decision. This may lead to an organisational phantasy of efficacy; the T.L.C is expected to be able to treat all conditions, other than conduct disorder. With growing research in the area of in-patient child psychiatry as well as community based care, it may become possible to ascertain more specific and appropriate treatment for different psychiatric conditions. Until then, the T.L.C is faced with a range of different cases, and an underlying phantasy that they should be able to treat the child as long as they are not conduct disordered. This can impact on the unit's interactions with parents as there is the unconscious assumption that they will be able to do the job the parents have failed at for so many years. There is also the often accurate awareness that the parents are a crucial factor in the origin and maintenance of the child's difficulties. Parent blame may lead to ambivalence about the involvement of the parents in the treatment of the child, especially when staff have anxieties about the parents ability to adhere to the programme the unit outlines.

5.3.2. Defensive strategies employed by the unit prior to admission

Before Josh was admitted to the unit, the staff raised concerns about the ability of the parents to change and comply with the behaviour modification programme. By raising such issues early,

before admission, the staff prepared themselves for the possible upcoming failure. The knowledge that comes from years of work in the field of child psychiatry is a heavy burden to carry. Staff can often predict the compliance or non-compliance of parents before the child has been admitted. By predicting and naming their concerns they protect against the fear of failure, and in some ways absolve themselves from the burden of having to ensure a cure. With this defensive pattern it is arguable that the unit is unable to think freely (non-defensively) about different ways of intervening. It is possible that the power of prediction influences the unit's ability to employ different strategies to effect change. It is difficult to assess the impact of naming the possibility of failure before it occurs, but there is little doubt that in a context characterised by very ill children the possibility of failure is always present. In this research there is also the added complication that in both cases the children are older than the optimum age of admission to the T.L.C. This could have exacerbated the perception by both staff and parents that the T.L.C is indeed the last resort for both these children. However, Fatima, although outside of the usual admission criteria, seemed a child that was manageable for the unit and her presence would address the need amongst the staff to have cases that do show improvement. Fatima's improvement of symptoms was predictable, as was the impact on the morale of the unit.

5.3.3. The importance of written material in the face of overwhelming anxiety

Both mothers reported being in an emotional state before admission that resulted in them not being able to absorb everything the unit was telling them during the pre-admission phase and tour of the facilities. Scharer (2002) suggests that parents should be given written information about the unit and that staff should volunteer information as the parents aren't often aware of what questions to ask.

Although the dissemination of knowledge is important, it is noteworthy that in both cases, the parents were not as concerned with the working of the unit as Scharer (2002) suggests. The parents had a vague idea as to who did what in the unit, but perceived the unit to function as a team. The parents stated that they were not concerned about the details of the unit, as they trusted the psychologist. Thus, it seems that the parents need to know primarily that the unit is functioning with a strong and clear authority figure who has a plan of treatment for their child and is overseeing the running of the unit. Trauma literature (for example, Herman, 1992) suggests that in times of extreme stress, individuals need to know that there is someone in charge and that things are being taken care of. Thus, although information may help acknowledge parents distress, it is the strength of the perceived leader of the unit and the unit's ability to contain anxiety that allays parent fears and would foster better therapeutic alliance. The dissemination of written material should be seen as a symbolic gesture of acknowledgement by the staff of the parental distress experienced prior to admission. The content of the material is not as meaningful as the gesture itself, as it represents that the staff have empathised with parents and are expecting them to be overwhelmed and unable to process a great deal of information.

5.3.4. The physical environment

Scharer (2002) reports that the environment of the unit can be distressing to parents. Interestingly, the perceptions of the unit differed in the two case studies. The Ismail family found it clean and appropriate and was positive about the physical environment of the T.L.C. The Kaplan family, however, felt differently, reporting that the unit had an unpleasant odour and that it was dark and not very child-friendly. The perceptions of the facilities at the T.L.C may be influenced by the families' socio-economic status; the Kaplan family is upper middle class, whereas the Ismail family is lower working class. They are thus accustomed to different kinds of

environments and provisions and there is little doubt that the T.L.C is a far more distressing place if the child and family is used to a more luxurious environment. However, socio- economic status is only one variable involved in how parents perceive the T.L.C's facilities. The unconscious battle of blame between staff and parents can manifest itself in many ways. For the Ismail family, the T.L.C was an appropriate place aided by the fact that Fatima's admission was only for one term. The T.L.C was not taking over a long term parenting function, rather they were assisting with a specific behavioural problem that was confined to social situations. In this way there was no competition between the parents and the unit.

In the Kaplan case, however, the mother was in a battle with the unit, defending vehemently against a perceived attack on her own mothering and home environment. Thus, she may have projected her anxieties onto the physical buildings and in this way the building/facilities themselves become linked to the underlying issues of treatability and blame. Her feelings about the facilities at the T.L.C may be an unconscious criticism of the unit's ability to mother her child. By implying that the environment does not meet her child's needs she is also implying that the unit as a whole is not better for her child than his own mother. In her own words, the T.L.C does not have a "punching bag" for Josh, he is only allowed that when he is home. Inherent in this statement is the belief that as the mother she understands her child's needs better than the T.L.C.

5.4. Admission

5.4.1. Parent non-compliance and other options for containment

Child psychiatric units involve parents in the treatment of the child in order to ensure sustainability after they are discharged, as most often children are placed back with their families

(Lask & Maynerd, 1998). However, the difficulties of effecting change not only within the child, but within the family system as well, is highlighted by the staff's interactions with the Kaplan family.

The T.L.C staff instructed Josh's parents to use behavioural techniques to contain their son, but, the mother reported she felt that sitting on her child or removing him into time out is more complicated when she is on her own at home with him. She noted that the staff are able to work in shifts at the T.L.C and call for help from other staff members, whilst at home she is often on her own and is unable to effectively manage his behaviour in the way that the staff recommended. The mother stated that she was often tired and exhausted and felt that the staff did not truly understand the extent of Josh's problematic behaviour. Her wish to video record his behaviour in order to show the staff, is a clear communication that the mother continues to feel that the staff do not realize how difficult things are for her and that her son remains uncontainable despite his good behaviour at the T.L.C. Although the staff did not doubt the severity of the child's behaviour they had never seen the extent of it at the T.L.C. The child's behaviour continued to remain good at the T.L.C and yet with the exception of two weekends, remained unmanageable at home on the weekends.

When the problem clearly lies within the family environment, it is understandable that such authors as Delaney (1992) and Violand and Williams (1994) argue for greater parental involvement in the milieu as a means to teach parents more effective management of their children. This is further supported by research that confirms parental involvement to be necessary for successful outcome in a child's hospitalisation (Jemerin and Phillips, 1988). Kutash and Rivera (1996) also conclude that the involvement of the family in the treatment of the child has a significant impact on the outcome. This kind of evidence highlights the problem of not including

parents more actively in the milieu, or perhaps even having staff spend time with the child in the family home.

This raises the question as to whether children like Josh are best suited for admission to a unit like the T.L.C. Perhaps community based care that offers treatment within the context of his family and home environment would have been more beneficial. In the past the staff of the T.L.C have gone into a family home to assist with the implementation and monitoring of a behavioural modification program. However, the cases have been with children whose diagnosis is clear and mainly 'organic' in nature (i.e. on the Pervasive Development Disorder spectrum), and in such cases, parents are seen as suffering terribly with the child, but staff do not attribute the blame of the child's behaviour to the parents. Although Josh has had a therapist in the home to assist with behavioural modification before, it was unsuccessful. It may, however, be argued that this was an individual therapist, and the T.L.C is a team who could work in shifts. In addition, Josh has associated the discipline of the T.L.C as residing only at the T.L.C, and, by entering his home, staff would bridge the split by introducing elements of the T.L.C into the home environment. There is little doubt that Josh's mother may find it difficult to have staff in her home, but this would provide staff with more opportunities to address the issues when they happen. It has to be considered that such an undertaking can burden an already under resourced unit. Josh is only one child and the unit can at times have up to eleven patients.

Within any psychiatric unit there are likely to be hair-line fractures within the system that may be amplified by difficult patients. The fault lines in a unit usually run along issues of hierarchy and power. Nurses may feel that they are at the frontline of the treatment programme, but are not empowered to make decisions regarding the formulation of the treatment plan. Even with a 'simple' case like Fatima, the psychologist had to make certain that he continued to reiterate the

specific plan to ensure a united team effort in Fatima's treatment. Staff were also clearly instructed to stay out of family dynamics and stick to a firm cognitive behavioural model. This, as the special nurse reported, had a uniting effect on the staff, which was in turn validated by an improvement in the child's functioning. If during a simple case there is a possibility for staff to split, it is likely to be amplified when the cases are more complex, such as the Kaplan family. Difficult cases may often call for different intervention strategies that are outside the nurses' normal operating procedures. There may be differences of opinion about the best intervention strategy and if the decision is made to increase parental access to the milieu or offer home based care, this would require already over– extended nurses to be stretched beyond their personal resources, and may also cause resentment.

5.4.2. Differing discipline techniques

In an incident outlined in the previous chapter, Josh's mother reported on an occasion where a nurse had threatened to put Josh in timeout or give him lines to write out because he "butted into" a conversation between the mother and the nurse. The mother felt this to be extreme and did not see the child's behaviour as problematic, furthermore she saw the nurse's actions as inappropriate and felt that, as the child's parent, it was her role to reprimand Josh if she felt it to be necessary. The mother was so taken aback that she could not respond in the situation, and this is highly unusual for her as she is naturally outspoken.

This incident highlights that some parents are highly sensitive to anything that they perceive to be a criticism of their parenting. In this instance the role of mother was taken away from the actual mother by the nurse and taps into the anxiety of inadequacy that exists within the parent. Green and Jones (1998) report that admitting a child to an in-patient psychiatric unit can result in

parents feeling deskilled. Nurses do fulfill the "in loco parentis" role in child in-patient units (Green and Jacobs, 1998), but in the presence of the actual parent have to remain sensitive to the possible underlying anxieties and differences in opinion of discipline styles and techniques. It is clear that, although the nurse was attempting to model for the mother the 'correct way' of disciplining her child, it was experienced as an affront to the mother's own parenting ability. This incident has to be seen in light of the mother's unconscious anxiety that she is to blame for her child's behaviour. In this instance the nurse was confirming the mother's worst fears and in an effort to defend against them, Josh's mother started to question the authority of the nurse.

5.4.3. Parent support groups organised by the unit

Literature suggests that parent groups are experienced as helpful and that parents enjoy access to other parents (Scharer, 1999). However, Fatima's mother and the Kaplan parents utilised parent group as a way to compare themselves to other parents. In this way they were able to rate the severity of their own child's problems as compared to other children at the T.L.C. In addition, Josh's mother felt that attending the parent groups contributed to her feeling even more burdened and despondent. Dreier & Lewis (1991) state that traditional parent groups utilised the psychoanalytic principles of exploring feelings and acquiring insight into the problem. The underlying philosophy is that if people understand how they feel, this understanding will free up energy, make them feel better and change their behaviour. During the treatment phase it seems that merely understanding and expressing feelings is not sufficient for parents of children with severe psychosocial problems. Although this may only be true for the two cases followed, it does seem that there is a need for parent groups to address specific parenting issues and offer direct psycho-educational input. Puotiniemi, Kyngas et al. (2001) note that problem-orientated and emotionally- orientated coping strategies, skills and palliative strategies correlate with impoved

parental coping during their child's psychiatric in-patient admission. Dreier & Lewis (1991), report that when parents were given information about diagnosis and specific management techniques, their feelings of mastery increase and blame and guilt decrease.

Josh's mother suggested a parent group prior to admission. The pre-admission phase is the most emotionally stressful for parents and may be the appropriate time for parents to share their anxieties about the upcoming separation from their child.

5.4.4. The issue of schooling

Both Fatima's mother and the Kaplan parents were concerned that the admission to the T.L.C would result in their children falling behind academically and that after discharge they would need to repeat the year of schooling. The Kaplan family had additional concerns; Josh was attending a private school and they were unsure as to whether the syllabus covered at the T.L.C was of the same standard as the private school. Furthermore, the T.L.C schooling caters for a range of children at different ages and different academic levels in the same classroom. In both cases the parents were concerned about whether their child would be able to receive adequate educational input.

It is interesting to note that the parents placed a great deal of emphasis on the schooling of their child, since they had conceptualised the T.L.C as a 'special school' as opposed to a hospital. In addition by worrying about their child's academic performance they are doing what 'good parents' are supposed to do; they are concerned about their child's future, but also in the event of parents wanting to take their child out of the T.L.C the utilisation of poor academic progress is a viable and acceptable argument.

The T.L.C does not address the issue of schooling directly with parents. Perhaps this is influenced by their history of a high turnover in teachers. The psychologist explained that the teacher had in the past been a scapegoat for all the unconscious anxieties of inadequacy and frustration in the unit and, in this way, the unit managed to 'expel' many previous teachers. However, with the introduction of staff groups and an understanding of the dynamics inherent in an in-patient unit, the T.L.C's current teacher has been with the unit for many years. It is possible that the history of the unit with regards to teachers, results in the unit being protective of the current teacher. There is also the underlying sense that staff feel these children have bigger issues to worry about than their schoolwork. For example, Fatima needs to be able to speak in school before she can complete all oral assignments that are required of her to pass the grade. Although academic work remains important to the T.L.C, it is not the central focus of the unit. The child's behaviour is the focus of admission for the unit and the school environment is considered to be the most appropriate and normalizing context in which to monitor and manage the behaviour.

Prior to discharge, the children attending the T.L.C are usually bridged back to the school they were attending or to a new school. Fatima had a very supportive educational environment where the teacher was in contact with the T.L.C. As a result, the programme was extended after discharge and the teachers were informed of how to carry out the behavioural interventions. In this way the T.L.C were effecting change whilst the child was an in-patient and after discharge. Fatima is a child who demonstrates that community based care and hospitalisation are not mutually exclusive treatment options but are often both part of a broader treatment plan for a child.

5.4.5. The financial cost of admission

The financial cost of admitting their child to the T.L.C was a concern for the Kaplan family. As the T.L.C is a government hospital, payment is calculated on a sliding scale. The Ismail family were a low income family and so, the cost of admission was not an additional strain to the family, especially as admission was only for one term. For the Kaplan family the expense involved was extreme. Incurring such a cost and not seeing much real change in the child in their home environment was a difficult situation. Just as staff need to see tangible improvements, so too do parents. The parents did report some marked improvements in their child, as he now sleeps in his own bed and sleeps through the night, but his behaviour does remain problematic. In addition, the lack of facilities at the unit were of concern to the Kaplans as they wondered where the money they were paying was going. Both the mother and the father raised questions about sporting facilities and the lack of extra-mural activities. It seems as if the parents were feeling that there was not enough of an improvement in their son to warrant the expense they were incurring. However, the parents were prepared to pay whatever they had to so, that in the future they could be assured that they had done all that they were able to. However, it is arguable that for the Kaplan family, it is easier to finance Josh's treatment than to accept the change that is required of their own behaviour.

Staff were aware of the amount of money the Kaplans were having to pay and how this may have influenced their opinions about the unit and that the parents might expect more from the staff and the facilities. However, the T.L.C is a unit that struggles with the few resources it does have, and prioritises addressing the lack of personnel over equipment for the children. In addition, the children in the unit often destroy the games or recreational/sporting equipment and thus the cost of replacement is a constant issue. Staff have stated that on the list of priorities for the hospital,

the psychiatric unit is at the bottom. The hospital is faced with needing to finance life saving equipment for patients and, as a result, books or tennis rackets for the children for example, at the T.L.C are not high on the priority list.

The discrepancy in priorities between staff and parents may lead to parents feeling disillusioned with the unit. Josh's mother expected the staff to be ingenious with the few resources they do have, for example, to invent badminton games with a string as a net. Although staff are aware of the need for children to be stimulated extra-murally, they are often exhausted and their main priority is the therapeutic containment of the psychiatrically ill children.

5.4.6. The importance of diagnosis

An issue that is not highlighted in the literature of child in-patient psychiatry is the importance of diagnosis and the impact that diagnostic issues may have on the staff- parent relationship. Different diagnoses imply different aetiological pathways, with perceived parent culpability varying depending on the diagnosis.

Fatima had a clear and undisputed diagnosis on admission. The mother, staff and even Fatima herself were aware of the long-standing diagnosis of selective mutism. Thus the child's problems were focused and the aim of admission was clear and one-dimensional; the aim of admission was to help the child talk more freely in social situations. The family also did not experience the child as quiet or reserved in their company. The family perceived her problems as falling outside the confines and safety of the family.

This is in strong contrast to the Kaplan family who experienced difficulties with the child both inside and outside the home. Josh's difficulties were also not easily encapsulated within one diagnosis, indeed there were several possibilities. Whilst the diagnosis of ADHD is one that both parents had assumed for their child, there were questions about underlying anxiety issues in addition to a previous diagnosis of ADHD. The diagnosis of ADHD allowed Josh's parents to make sense of his behaviour, whilst they both still acknowledged that he had separation issues. The diagnosis enabled the father to tell people that his son was at the T.L.C to help him with his attention problems. He was also able to blanket all the issues under one diagnosis. ADHD is a diagnosis that is known to both professionals and lay people and is commonly perceived to be a mostly medical condition. However, during Josh's admission the staff changed the diagnosis from ADHD to a V-Code of parent-child relationship issues, and an underlying Generalised Anxiety Disorder. They also placed him on an anti-depressant. This created great confusion for the mother of the child as she continued to feel that her child was ADHD. The father did not speak of the change in diagnosis and continued to talk of his son as if the diagnosis remained ADHD.

Harborne, Wolpert and Clare (2004) note how differing perspectives with regards to a child's ADHD diagnosis, may result in parents feeling blamed by professionals and family members for their child's difficulties. This feeling of being blamed also results in parents experiencing significant emotional distress. Some parents in the Harborne et. al (2004) study report that their own mental health suffered as they experienced problems such as anxiety, weight gain, sleepless nights and beliefs that they were going mad. Josh's mother reported most of these symptoms. The uncertainty of the ADHD diagnosis and perceived blame by professionals implicit in the V- code diagnosis, led to Josh's parents questioning their own judgment. Josh's mother questioned the

diagnosis and discipline techniques but prefaced the statement with, "I don't know - I am not a professional."

It is important to note that Harborne et al. (2004) state that the experience of blame dissipates once the parents receive a diagnosis of ADHD (the research is specific to ADHD). Such a diagnosis confirms their view of the biological nature of their child's condition. In this way Hinton and Wolpert (1998) refer to ADHD as being a 'diagnosis of forgiveness' for parents. However, when the diagnosis is disputed by professionals it can result in parents battling to convince professionals that something is wrong with their child (Harborne et al., 2004). Josh's mother reported that the staff find nothing wrong with her child but that she has a different view due to her own experience of her child and the research she has done. This implies that she is indeed in a battle with the unit to prove her son's diagnosis as being ADHD.

Diagnosis is an issue that is closely linked to the issue of understanding the nature and cause of problem behaviour. Ascertaining aetiology and looking for reasons as to why a child behaves as s/he does infers something about parenting styles and techniques and leads into an examination of the internal struggle parents face with regards to feeling blame for the child's behaviour. In the Kaplan family the change in diagnosis moved the case away from a medical understanding and aetiology to one that is a result of the environment and parenting techniques. The change in diagnosis confirmed the mother's underlying unconscious battle against self-blame; that the difficulty resided in her and not in her son. The mother defended against the fear of self-blame by adopting a narrative of 'child blaming' where her son is seen to have an inherent difficulty and is responsible for the emotional upheaval in the family (Harborne et al., 2004). The mother understood all Josh's behaviour through this particular lens; when Josh behaved badly at home, but normally at the TLC the mother attributed this to the child feeling safe with her and thus

using her as a punching bag to release all the tension he had stored over the week at the T.L.C. Maintaining the diagnosis of ADHD and attributing the difficulties to something inside Josh allowed her to defend against the possibility that she is indeed the parent who is the cause of the pathology. Josh's father, however, in the first interview defended against the anxiety of being a 'bad parent' in a different manner. He started the interview by assuming responsibility and asking whether perhaps it was the divorce or the fact that he wasn't very involved with his son that caused his son's problem behaviours. In this way he defended against the possibility of feeling blamed by the interviewer by accepting responsibility before anything could be implied or suggested.

It is essential that staff are aware of the implications that a diagnosis can have on parent's perceptions of themselves and their child. Clinicians have a sense of accomplishment when attaining the correct diagnosis as it informs the future management and treatment of any case. It can also result in the case feeling less overwhelming for the staff of the unit. However, staff must be aware that a change to a V-code diagnosis exacerbates the parent's feelings of self-blame and inadequacy, and this in turn, can greatly affect the nature of the therapeutic relationship between staff and parents.

5.4.7. Staff defences against blaming parents

Inherent in a psychodynamic understanding of human development is an assumption of the importance of the parent's contribution to pathology. The staff of the T.L.C commonly hold the parents responsible for a child's problems, but try to disguise or camouflage this in order to establish and maintain a therapeutic alliance.

Josh's behaviour remained appropriate at the T.L.C, yet unmanageable at home. Based on the observation that the child remains containable within the unit, it is likely that the staff will continue to feel that the parents are responsible for the maintenance of the child's problem behaviours. However, staff at the T.L.C are aware of the impact of parent blaming and employ different defences to enable them to continue to work with parents they may feel to be responsible for the child's behaviour. When Josh's mother comes to the unit, staff avoid her. This is in part due to the fact that the mother is experienced by the staff as overwhelming, demanding and intrusive, but it is also possible that the staff are unsure about what to say to the mother. For the staff the evidence is clear; the child is well behaved at the T.L.C but not at home. This implies that, unlike Josh's parents, the staff are able to care for Josh in a manner which alleviates his symptoms. In the interview with staff, the psychologist also reported that the experience of the unit in the past is that children have benefited from admission even if no change has resulted in the parents. This underlying belief within the unit, may allow for staff to avoid contact with the mother, without feeling that they may be in some way jeopardising the treatment; even in the event that the parents do not shift, the child will nonetheless benefit from admission to the T.L.C.

In addition, in order to enable the unit to continue working with the parents the unit adopts a 'sympathetic' stance towards understanding the parents' difficulties. This approach is likely to be framed as follows: it is not that they do not want to manage their child, it is more that they do not have the skills or insight to do so. In this way the staff are able to continue to work with both the parents and child despite little or no change occurring in the home environment. This "aghh shame" defensive pattern also "protects" staff from having to directly blame the parents for the child's difficulties. Such a position implies that if the parents could do better they would and it also protects the staff from feeling disheartened and defeated by the lack of progress made within the family. Thus, by naming the possibility of failure early on in the case as well as seeing the

parents as inherently unable to shift, the T.L.C is justified in not extending the treatment of the child to include a greater involvement of the parents in the milieu and treatment of their child. In Josh's case, this arguably defensive pattern may have also resulted in the staff not undertaking to treat the child within his home environment, as the underlying belief was that the parents would not be able to consistently adhere to the recommendations made by the staff.

5.4.8. Relationships between staff and parents: the complexities of therapeutic alliance

Therapeutic alliance is a complex notion that involves both conscious and unconscious aspects. Although the nursing literature (Scharer, 1999; Puotiniemi,Kyngas et.al, 2001; Gudmundsson & Tomasson, 2002) addresses the conscious aspects of therapeutic alliance, there is little consideration of the unconscious issues that may impact significantly on how both the staff and the parents relate to one another. Despite this, the literature can provide insights into specific issues (such as the previously discussed dissemination of written material) that staff can address to encourage a good relationship with parents.

Scharer (2002) reports that parents need the staff to demonstrate care towards their child, and this encourages a positive relationship between staff and parent. Both Fatima's mother and Josh's parents felt that the staff at the TLC worked together and had a warm and comforting influence on their children. Fatima's mother reported that she felt supported and helped by the special nurse. Josh's mother also mentioned the fact that the nurses were female and that helped her feel that Josh was receiving the emotional nurturance he required.

Green (1998) and Scharer (2002) mention the need for staff to constantly reflect on their own assumptions about parents and how these could influence the nature of the relationship. This

ability to reflect is crucial in a psychiatric unit, where the children and families may project overwhelming emotions and anxieties onto them. Throughout the results there were moments when staff's assumptions about parents were incorrect. For example, Josh's second "special nurse" reported that she felt that the mother did not like her, but that their relationship was starting to improve. However, the mother reported a very different account of the relationship and said how she preferred the second special nurse. The nurse's own phantasies of inadequacy and perhaps fear of being 'second best' influenced the way in which she felt about the mother. This incident highlights how staff as well as parents have unconscious phantasies about one another, that may influence the way in which they engage. Although the literature addresses the conscious issues involved in expectations it does not explore the impact of the staff's own phantasies on the nature of the therapeutic alliance. However, in reality, the negative impact of a few isolated incidents of misatunement on the therapeutic alliance between staff and parents is questionable. It is only when perceptions are left unchecked, and when staff do not have staff groups or supervision to explore their own phanstasies, that issues inherent in the staff may negatively affect the relationship with the parents. The misattunement between parents and staff is an issue to be considered when a unit needs to rate therapeutic alliance. It may be advisable to allow both the staff and the parents themselves to rate the quality of the relationship with each other.

Scharer's (1999) conceptualization of the therapeutic alliance implies that if staff fulfil certain required obligations, such as open communication and the dissemination of knowledge, engagement is more likely to occur. This is arguably a simplistic approach since therapeutic alliance is embedded in so many other issues and has both a conscious and unconscious life. Scharer (1999) also suggests that therapeutic alliance can be seen as a continuum with working alliance at the high end of the continuum that begins with engagement. However, this model does not allow for the quality of the engagement to be assessed. For example, Fatima's mother was

engaged with the process in terms of attending meetings and doing what was expected of her, and Josh's father did the same thing. However, in both cases the staff reported that they experienced them as compliant as opposed to truly being engaged with the process of treatment of their child. This example may show that engagement is not necessarily a pre-cursor for working alliance and that movement to a positive working alliance may be dependent on other issues such as the quality of the engagement and the unconscious phantasies about blame.

Scharer (1999) also mentions disengagement between staff and nurses that can result from nurse's changes in working schedules or emotional upset. During the second term of Josh's admission, his mother refused to attend parent groups and questioned the training and skills of the staff. This questioning of the staff's competence began after the previously mentioned disagreements in parenting and discipline styles emerged. Scharer (2002) suggests that perceived mismanagement by the staff of any child erodes a parent's trust in the staff being able to care for their child successfully. It is important to note that it is perceived mismanagement and not actual mismanagement that can influence the level of trust that a parent feels towards the unit. Josh's mother felt that the strict discipline at the unit was unrealistic and also did not agree with the no-hitting policy and continued to smack her child if she felt it to be necessary. However, her disagreements with the unit did not cause her to withdraw or disengage. Perhaps her defences are so strong after many years of living with Josh, and she is mobilised to prove to the T.L.C that her son's issues are a result of his own difficulties. This is an instructive example of the complex nature of therapeutic alliance; although the mother disagreed with many of the unit's rules and techniques she continued to attend sessions with the psychologist and was a regular presence in the unit voicing her concerns and opposition openly.

Scharer (1999) also reports that different alliances can exist with different staff members. This was true for both the Kaplan family and Fatima's mother as they reported an easy relationship with those nurses they had more contact with. Although the parents were unsure as to what the different professional responsibilities were in the unit they were all able to recognise the psychologist as the head of the T.L.C. The understanding of the hierachical system of the T.L.C may result in parents relating differently to the psychologist as opposed to a nurse.

The hierarchical system also informs the relationships within the unit. It seems as if the nurses are responsible for the child and the psychologist (or social worker if present)is in charge of the parents. This split also encourages the different roles inherent in the child in-patient psychiatric unit (Green and Kroll, 1997). Traditionally the psychologist and/or social worker is responsible for maintaining a working relationship with the parents, yet the nurses carry the "in loco parentis" role which requires them to remain allied with the child. In this way the parents are seen as the psychologist's patients and the child remains the nurse's patient. Without a social worker the psychologist has to contain these tensions within the T.L.C, balancing the need for him to remain aligned with the parents whilst understanding the staff and the difficulties of parent blaming that are inherent when nurses carry the "in loco parentis" responsibility of a child. The argument for increasing parent access to the milieu would challenge this split and perhaps encourage the conceptualisation of the entire family as being the unit's patient, instead of the child alone.

5.5. Conclusion

The above section explored the issues raised by the current study of therapeutic alliance in the light of relevant literature. All the issues mentioned in this chapter influence the relationship between staff and parents. The two cases are different and provide insights into the functioning of

the T.L.C unit. When a case is one-dimensional; implying a clear focus, simple diagnosis and manageable and attainable goals, the unit works in a unified manner. However, when the case is more intricate with difficulties inherent in the relationships between parents and staff, the functioning of the unit is placed under greater pressure. The concluding chapter of the thesis returns to the two main aims of the research: firstly, how do parents experience the admission and treatment of their child to a psychiatric in-patient unit and, secondly what fosters or hinders therapeutic alliance in child in-patient psychiatry?

CHAPTER SIX

6. CONCLUSIONS AND RECOMMENDATIONS

6.1. Introduction

This chapter draws together the key issues highlighted in the literature review as well as the major themes that emerged from the results. The issues are arranged under the aims of the thesis. Thereafter the limitations of the study are discussed and the chapter concludes with recommendations for future research and for clinical practice.

6.2. Conclusions

6.2.1. How do parents experience the admission and treatment of their child to a psychiatric in-patient unit?

Living with a psychiatrically ill child is a traumatizing experience for the family (Klauber, 1998) and it increases the likelihood of parents themselves suffering from symptoms such as depression, anxiety and isolation (Gundmundesson & Tomasson, 2002). This is an issue professionals in the area of child psychiatry need to be aware of, as they may be required to make the appropriate referrals for parents. This research showed that parents are also influenced by the social stigma of both living with a psychiatrically ill child and admitting the child to a unit such as the T.L.C. When professionals and extended family or friends question the parents on issues relating to their child, the parents experience this as extremely distressing and this increases the chance of parents feeling blamed for their child's problems. However, the extent of trauma experienced by parents is variable and dependent on a number of factors such as diagnosis, external support mechanisms and previous positive relationships with helping professionals. Klauber (1998) warns that professionals need to be aware of the trauma that parents can

experience but they should also retain an understanding that each case is different and that the level of trauma will vary across different cases and parents. Thus, parents' experiences of admitting their child to the T.L.C will depend on many factors and will vary according to the nature of the case and the issues intrinsic to the family.

Scharer (1999) reports that admission is the most difficult time for parents and in both cases the parents did find the most stressful time to be prior to admission. Parents struggled with the decision of handing over care of their child to strangers and were also worried about the child's safety. These fears were so overwhelming that both mothers in the study were unable to process all the information provided by the unit prior to admission. Underlying all these concerns is the fear that on admission parents will be blamed for their child's behaviour or that admission will result in parents being 'exposed' as bad parents. Other main concerns included: the financial cost of admission, the lack of facilities at the T.L.C, the sustainability of improvements in the child's symptoms and the academic standard of the schooling at the T.L.C. It was felt by the parents interviewed that the T.L.C's academic standard was not equivalent to their children's original schools. This was exacerbated by the different age and academic levels within the T.L.C and, for the Kaplan's, the fact that Josh came from a private school.

A child psychiatric ward is an unfamiliar and daunting place for most parents. Warm, empathic staff assist in allaying parents' fears and apprehensions. By staff providing clear, and also written unambiguous information about the procedures involved in the functioning of the unit, the parents should have a better understanding from the outset as to what to expect.

6.2.2. What fosters or hinders therapeutic alliance in child in-patient psychiatry?

A clear definition of therapeutic alliance in child in-patient psychiatry is elusive. However it is a term broadly used to describe the relationship that exists between the patient and the caregiver. Therapeutic alliance in in-patient child psychiatry is a complex concept that is dependent on both conscious and unconscious factors inherent in the staff and families of psychiatrically ill children. Research is suggesting the importance of parental involvement as a predictor of improved outcome during child in-patient admissions, thus it is essential for staff to understand the dynamics inherent in therapeutic alliance. In contrast to the available literature, the results of this research suggest that engagement cannot be ensured by staff simply adhering to a set of guidelines, as there are often unconscious mechanisms in both staff and parents that can impede therapeutic alliance. Central to the understanding of the difficulties inherent in therapeutic alliance in child in-patient psychiatry, is the interplay between the often unconscious dynamics of staff holding parents responsible for the child's pathology, and parents themselves defending against feelings of inadequacy and blame.

This study confirms that therapeutic alliance cannot be measured merely by attendance. Josh's father was present at all the meetings required of him, yet staff did not feel like he was truly engaged with the process. This indicates that a parent's ability to engage openly and honestly with staff may be dependant on issues such as, their ability to access emotional material, their previous relationships with helping professionals, and their response to authority. Thus, measures of therapeutic alliance need to consider the quality of the relationship and interaction between staff and parents. Scharer (2002) suggests that the therapeutic relationship is constantly changing and is influenced by many factors including the child's current level of functioning and improvement. Scharer (2002) also suggests that disengagement is not necessarily the end of the

therapeutic relationship as re-engagement can occur. Thus, it is important for staff to be aware of when disengagement is likely to occur. Parents may withdraw when they feel deskilled by the unit. This withdrawal may be far subtler than merely non-attendance. Parents may adopt a compliant approach with regards to attendance but resist the unit in terms of their suggestions and recommendations. They may also withdraw when they feel they are receiving no particular benefit from an activity, i.e. parent groups. In addition, this study has shown that when parents perceive mismanagement by the staff of their child, their trust is eroded in the staff being able to care for their child successfully. Other issues that can result in the parent becoming disengaged are differences in opinions about parenting styles, discipline techniques and diagnosis. The diagnosis of a child is linked to the beliefs parents hold about the origins of their child's behaviour. Although accurate diagnoses provide invaluable insights into the further management and treatment of cases, it remains crucial to recognize that changes to a V-code diagnosis can compound parents underlying belief that they are to blame for their child's illness.

The importance of a strong and containing authority figure is essential to the effective management of a child in-patient psychiatric unit. This is important for both staff and parents. In this study the staff trusted the psychologist in the formulation and goals for each child. In addition, the parents saw the psychologist as a man of integrity and knowledge who had a clear plan for the treatment of their child. Parents also felt that the nurses were warm and empathic and placed the welfare of the children first. As mentioned by Scharer (2002) this is a crucial element in influencing how the parents feel towards the unit. This underlying and pervasive feeling by both sets of parents fostered and improved the likelihood that a parent would re-engage in the event of disengagement.

Scharer (2002) also speaks of a rare occurrence: the development of the "working alliance". This is seen as an unusual intensity in a positive relationship, often resulting from an extended duration to the relationship. However, it cannot be stated that such a positive relationship has to exist in order for the parents to be actively engaged with the unit. Intense negative feelings towards the unit can paradoxically cause the parent to feel more connected with the unit and result in open discussion and dialogue. When parents and staff agree it does seem that the relationship is easier, but agreement or consensus does not necessarily imply full engagement of the parents. Thus, the intensity and involvement of parents cannot be measured merely by attendance or consensus. The main themes summarized here suggest a number of interesting directions for future research and clinical practice. However, before these are considered, the limitations of this study need to be discussed.

6.3. Limitations of the study

Inherent to child in-patient psychiatric research is the issue of a very small sample size. During the beginning stages of this research the T.L.C only had three in-patients admitted to the unit. In addition there is a scarcity of child in-patient psychiatric units and there is a lack of consistency across the units that do exist. The narratives that were elicited were co-constructed between the interviewees and myself. Thus, the findings of this research cannot be generalized across to other units or families of psychiatrically ill children. However, the information gained from the interviews provides insights into the particular lives of these parents of psychiatrically ill children as well as the staff of this child psychiatric unit. These insights depended on developing a deeper understanding of each case rather than reviewing a number of cases in a shallow way.

The interviews and case conferences provided multi-layered information that aided in the understanding of the complex topic of therapeutic alliance. Although the information gained provides a starting point to understanding the different facets of therapeutic alliance it was limited in time and scope. The parents of the two families tracked were interviewed twice, which could result in the subtle changes of relationships being omitted at different phases of admission. The first interview was also conducted approximately four weeks after admission, and so parents were speaking of their anxieties prior to admission retrospectively. It could be argued that a more accurate reflection of their experience might have been obtained if the interview had been conducted prior to admission. Only two staff members, i.e. the psychologist and special nurse assigned to the case, were interviewed twice. Although the case conferences were attended, it is not the appropriate forum for staff to discuss interpersonal staff issues that could influence how they are feeling about a child or family. Thus, staff dynamics that were occurring in the unit were assessed based on interviews with two staff members and case conferences. It could be argued that in order to gain a deeper understanding of the constant fluctuations in staff dynamics and ward atmosphere a researcher would have to be based in the unit, however one of this study's aims was to explore the process of admission and treatment from a parental perspective.

6.4. Recommendations

The research into parental alliance in child in-patient psychiatric units remains in its early phase of development. Although hampered by very few units, small sample sizes and already overburdened staff, further research could make meaningful contributions to child mental health practices both within the context of hospitalisation and community-based care.

- Research into the lives of parents with psychiatrically ill children will provide mental health professionals with a deeper understanding of the challenges facing these parents. It would also enable professionals to cater for the needs of families by providing information and appropriate referrals for parents.

- Diagnosis also seems to be closely linked to parental experiences of their child with mental health professionals. Studies such as Harborne et al, (2004) suggest that future research into the meaning of diagnosis for parents of psychiatrically ill children is needed.

- Research into the most effective form of intervention (i.e community intervention, in-patient treatment, or family admission to a unit) for children with differing psychiatric conditions may help to inform a decision of the most appropriate method of intervention.

- A clearer definition of therapeutic alliance in in-patient child psychiatry is needed. This definition should encompass the many intangible variables that inform therapeutic alliance, such as the parents' unconscious anxieties, the atmosphere of the unit and the organisational dynamics of the unit.

- Further research to explore the relationship between therapeutic alliance and child outcome is indicated. However, this research would benefit greatly by assessing family engagement as more than a measure of attendance and should allow for parents to rate their engagement in the therapeutic alliance with the unit.

- Long-term follow up studies would allow child in-patient psychiatric units to assess the effectiveness and sustainability of admission and treatment many years after discharge.

The above suggestions focus on possible further research initiatives. However, this study also highlighted clinical issues which may be useful for the staff at the T.L.C.

- Pre-admission seems to be the most stressful time for parents. A parent group for new parents, prior to the child's first day, may be useful to address the anxieties inherent in the admission. In addition to verbal communication, written material about the unit, its facilities and commonly asked questions may also assist the parents and indicate an understanding and compassion from the unit.

- The two cases followed were vastly different and indicate how staff need to be able to adapt treatment plans and management goals. As in-patient treatment is highly expensive and the T.L.C seems to be the only unit available in the Western Cape (if not South Africa), community based and home intervention programs may be appropriate for those cases that are not suited for T.L.C admission. The T.L.C, although already understaffed, may be able to increase their outpatient programme to include community-based therapy for children where in-patient treatment is not indicated.

- Cases where there are difficulties with parents adhering to the behavioural modification programme may benefit from staff increasing the access of the parents to the milieu environment. Thus, parents may participate in the ward and staff would be onsite to assist

with the dissemination of knowledge and the modelling of more effective methods of behavioural management.

- Parent groups may also benefit from including more psycho-education for the parents. Although they do receive this from the weekly meetings with the psychologist or social worker, parents did indicate that more was required. Already troubled parents may experience the support group and listening to other stressful home environments as a further burden rather than a source of support. It may be beneficial to conduct an informal survey at the beginning of a support group to ascertain the parents' needs and expectations of the group.

- Academic performance in the schooling of the patient also seems to be a concern of parents. It may be beneficial for parents to meet one-on-one with the teacher as soon as these issues arise.

- The T.L.C adopts a psychoanalytic understanding of both themselves and the cases they admit to the unit. In light of this, this research will be presented to the staff in order to discuss issues highlighted in the literature e.g. Klauber (1998), Scharer (1999, 2002) and Harborne et al. (2004). These authors raise issues that include the conceptualisation of parents of psychiatrically ill children as being traumatised people, the needs and expectations of parents of mentally ill children and the impact of diagnosis on parent's understanding of their child's problems. By discussing some of these issues staff may grow in their understanding of the parental perspective of living with a psychiatrically ill child

and also gain a deeper insight into the unconscious aspects that may influence parental interactions with the unit.

Current trends in child in-patient psychiatry advocate for more family involvement and shorter hospitalisations. Within the South African context the T.L.C battles with limited staff, financial constraints and few appropriate therapeutic alternatives for children in need. Despite this, there is little doubt that the staff of the T.L.C continue to assist children and families who remain unable to benefit from outpatient treatment. Thus, further research into the effectiveness of the program could assist in lobbying for additional resources.

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APPENDIX A

Initial interview with parents

1. Presenting Problem: What do you as parents understand it to be, what have they tried to do already, who has given them advice?

2. Referral Route
   Who did they see?
   When and why
   Other testimonials (previous experiences with therapeutic interventions)

3. How do they feel about being at the T.L.C?
   Family (parents)
   Child
   Siblings

4. What do they think of the unit?
   Facilities
   Staff
   Visiting hours
   How would they describe their relationship with – psychologist/special nurse?
   Are there things you would have wanted to ask the psychologist/nurse?
   If not why?
   Are things as you expected?
   Has the functioning of the unit been described to you?

5. How do you think the unit works?

6. What is the aim of admission?

7. What did they tell the child/family/friends about the admission to the T.L.C?

8. How do you feel about leaving your child at the unit?

9. How did the child react on their first day?

10. How long will your child be admitted for?

11. How will you know if the treatment is a success?

12. What has been the most difficult part for you so far?
    Was there anything the unit could have done?

13. What part has felt the most manageable?
    Was there anything the unit did to make it more manageable?

APPENDIX B

Initial interview with staff

1. Presenting Problem: What do you as staff understand it to be, what do you feel the parents understand it to be?

2. Referral Route – do the staff know and understand the referral process the family has been through?
   Who did they see?
   When and why
   Other testimonials (previous experiences with therapeutic interventions)

3. How do you as staff think the family feel about being at the T.L.C?
   Parents
   Child
   Siblings

4. What do you think the family think of the unit?
   Facilities
   Staff
   Visiting hours
   How would you describe your relationship with the parents– psychologist/special nurse?
   Are things as you expected?

5. What is the aim of admission?

6. What do you think the parents have told the child/family/friends about the admission to the T.L.C?

7. How do you think the parent feel about leaving their child at the unit?

8. How did the child react on their first day?

9. How long will the child be admitted for?

10. How will you know if the treatment is a success?

11. What do you think has been the most difficult for the family so far?

12. What has been the most difficult for the staff so far?

13. What do you think has been the most manageable for the family so far?

14. What part has felt the most manageable for the unit with regards to this case.

APPENDIX C

Follow-up interview with parents

1. PRESENTING PROBLEM: what do they understand it to be, has it changed since admission?

2. Referral Route – what do they think now about it? Had they wished it to be different?

3. How do they feel about the T.L.C?
   Family (parents)
   Child
   Siblings

4. What do they think of the unit?
   Facilities
   Staff
   Visiting hours
   How would they describe their relationship with – Willem/Nurse
   Are there things you would have wanted to ask the psychologist/nurse
   If not why?
   Are things as you expected, or has anything surprised you?
   How do you think the unit functions?

5. Tell me what you have learnt about the unit?

6. What is the aim of admission, has it changed?

7. What did they tell the child/family/friends about the TLC? – has the story changed in any way, have they told more people?

8. How long was the admission and was it what you expected in duration?

9. Has the treatment been a success?
   If yes, what do you think helped?

10. What do you feel about the unit and their techniques?

11. What has been the most difficult part for you so far?

12. What part has felt the most manageable?

13. Would you recommend the unit to other parents with similar issues?

14. Did you have contact with any other parents?

APPENDIX D

Follow-up interview with staff

1. Has the presenting problem changed since admission?
2. How would you rate this case compared to others?
3. Why did the intervention work, or not work?
4. Did the case take up more or less time than is usual for most cases?
5. How do you think the parents feel about the unit?
6. How do you feel about the parents?

   Special nurse

   Psychologist
7. How do the rest of the team feel about the parents?
8. How do you feel the unit managed the case?
9. What was the most difficult part of having this case admitted?
10. What do you think the parents have found most difficult?
11. How did the child relate to the other children in the unit?
12. Was there anything that surprised you about the case?
13. Do you think the parents would recommend the unit to other parents with similar problems?
14. Would you take a similar case again?

APPENDIX E

Consent Letter

Dear _____

I am a clinical psychology masters student at the University of Cape Town. As part of my degree I am required to complete a research thesis. The research I am undertaking is involved in gaining a better understanding of what parents experience when their child is admitted to the Therapeutic Learning Centre at Red Cross Children's Hospital. Its aim is to help the unit gain a deeper insight into what parents find particularly challenging or helpful. This is in a continued effort to improve procedures and family involvement with the unit.

Participation would involve 2 open-ended interviews, which would be taped, at a time and place suitable to you. Although the staff will be aware of which families I am interviewing, your confidentiality will be ensured outside of the T.L.C.

If you would be willing to participate please sign the consent below. Should you wish to discuss anything please don't hesitate to contact me.

Kind regards,
Robyn Marks

I _____ hereby consent to participation in 3 taped interviews concerning the experience of admitting a child to the Therapeutic Learning Center. All information will be kept confidential.

_____
(signature)